

DOCUMENT RESUME

ED 407 180

PS 025 494

AUTHOR Parker, Faith Lamb, Ed.; And Others
TITLE Making a Difference for Children, Families and Communities: Partnerships among Researchers, Practitioners and Policymakers. Summary of Conference Proceedings of Head Start's National Research Conference (3rd, Washington, D.C., June 20-23, 1996).
INSTITUTION Columbia Univ., New York, N.Y. School of Public Health.; Society for Research in Child Development.
SPONS AGENCY Administration for Children, Youth, and Families (DHHS), Washington, D.C.
PUB DATE Jun 96
NOTE 726p.
CONTRACT 105-94-2009
PUB TYPE Collected Works - Proceedings (021)
EDRS PRICE MF04/PC30 Plus Postage.
DESCRIPTORS Child Health; Child Rearing; Day Care; Early Childhood Education; Educational Policy; *Educational Practices; Educational Research; Low Income Groups; Mental Health; *Partnerships in Education; Program Evaluation; Research and Development; School Readiness; Substance Abuse; *Theory Practice Relationship; Violence
IDENTIFIERS Administration for Children Youth and Families; *Family Support; *Project Head Start; Resilience (Personality)

ABSTRACT

The first section of this book of proceedings contains the text of the conference's opening keynote speech by Edward Zigler and six other special sessions. The second section presents the texts of 61 symposia, divided into nine topical areas. Topics are "Head Start Partnerships, Research, Practice, and Policy," "ACYF Research, Demonstration, and Evaluation Branch Symposia," "Community Violence and Substance Abuse," "Early Education, Child Care, and School Readiness," "Family Support and Parenting," "Health, Mental Health, and Resiliency," "Methods for Assessing Low-Income Minority Families," "Program Evaluation," and miscellaneous topics. The third section presents short descriptions of approximately 200 poster sessions divided into 21 topical areas: (1) adolescent mothers; (2) research from other countries; (3) child care; (4) child mental health; (5) children with special needs; (6) cultural and linguistic diversity; (7) curriculum and classroom practice; (8) family and community; (9) family support; (10) health and nutrition; (11) infants and toddlers; (12) literacy and home learning; (13) mental health; (14) new methods; (15) normative child development; (16) parenting; (17) professional development; (18) social and academic competence; (19) homelessness; (20) poverty; and (21) transition. Appendices include a list of cooperating organizations and program committee members, list of peer reviewers, index, and directory of participants. (BC)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

ED 407 180

SUMMARY OF CONFERENCE PROCEEDINGS

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

X This document has been reproduced as
received from the person or organization
originating it.
☐ Minor changes have been made to improve
reproduction quality.

• Points of view or opinions stated in this docu-
ment do not necessarily represent official
OEI position or policy.

Making a Difference for Children, Families and Communities:

Partnerships among Researchers,
Practitioners and Policymakers

Head Start's Third National Research Conference

Washington, DC
June 20-23, 1996

PS 025494



presented by

The Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services

in collaboration with

Columbia School of Public Health
Center for Population and Family Health

and

The Society for Research in Child Development

BEST COPY AVAILABLE

**SUMMARY OF
CONFERENCE PROCEEDINGS**

**Making a Difference for Children,
Families and Communities:**

Partnerships among Researchers,
Practitioners and Policymakers



**Head Start's Third
National Research Conference**

Washington, DC
June 20-23, 1996



presented by

The Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services

in collaboration with

Columbia School of Public Health
Center for Population and Family Health

and

The Society for Research in Child Development

ACKNOWLEDGMENTS

This document was prepared by

**Columbia School of Public Health
Center for Population and Family Health
60 Haven Avenue, B3
New York, NY 10032**

**under Contract No.
105-94-2009**

in collaboration with

**The Society for Research in Child Development
University of Michigan
300 N. Ingalls, 10th Floor
Ann Arbor, MI 48109-0406**

for the

**Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services**

**Project Officer: Esther Kresh
Administration on Children, Youth and
Families, Head Start Bureau**

**Editors: Faith Lamb Parker
John Hagen
Cheryl Clark
Ruth Robinson**

**Editorial Assistants: Eileen Conneely
Lynne Erler
Goli Fassihian
Katherine Rogers**

Cover design and layout by: Kay Castelle

1997

Table of Contents

Special Sessions

Opening Session — Edward Zigler	1
Opening Night Reception — Ann Rosewater	14
Luncheon I — Olivia A. Golden	16
Luncheon II — Valeria Lovelace	22
Plenary I	
Psychosocial Adversity: Risk, Resilience, and Recovery	27
Plenary II	
The Reality of Partnerships	43
Plenary III and Closing	
Translating Research into Practice	57

Symposia

Head Start Partnerships, Research, Practice, and Policy

Head Start Research: Informing Quality Practices and Policy Construction	75
The Reality of Partnerships	89
Case Studies of University/Community Research Partnerships	102
Implementing the New Head Start Research Agenda: The Head Start Quality Research Center Consortium	106
Early Head Start Forum	116
Head Start Correlate Studies	127
The Design of a National Longitudinal Study of Head Start Children	133
Head Start Research Fair	144
Wider Windows on Head Start	149

ACYF Research, Demonstration, and Evaluation Branch Symposia

Evaluation of the Head Start/Public School Early Childhood Transition Demonstration	163
Evaluation of the Head Start Comprehensive Child Development Program (CCDP)	175
Evaluation of Head Start Family Service and Head Start Family Child Care Demonstrations	186
Descriptive Studies of Head Start Bilingual/Multicultural Services Population and the Migrant Head Start Program	197
Descriptive Study of the Head Start Health Component	206

Community Violence and Substance Abuse

Strategies for Working with Children and Families from Substance-Exposed Environments: Research and Its Implications for Head Start Practitioners and Policymakers	214
Preventing Community Violence: What Works?	216
Addressing Violence in the Community, Part I: Violence-Prevention Strategies	228
Addressing Violence in the Community, Part II: Strategies for Helping Traumatized Children	233

Early Education, Child Care, and School Readiness

New Kids on the Block: The National Institute on Early Childhood Development and Education/U.S. Department of Education	242
Head Start: Part-Day Program in a Full-Day World	250
Early Child Care in the Lives of Low-Income Children: A Substudy of Head Start-Eligible Children from the NICHD Study of Early Child Care	253
The Impact of Professional Development Experiences on Quality in Child Care	265
Emerging Narrative Abilities among Low-Income Children: Influence of Practices in the Home, Intervention, and Relationship to Social Competence	269

Family Support and Parenting

Longitudinal Research with High-Risk Families	275
Enhancing Resiliency through Family/Community Interventions with High-Risk Children: Current Canadian Models	281
A Head Start for Families Experiencing Homelessness	284
Family-Centered Home Visits: How Do We Know They Are Family-Centered?	289
Children in Out-of-Home Care	293
Parenting in Early Intervention Programs: Program Goals, Effects, and Measurement Strategies	306
What Do We Know about Enhancing Parent/Child Communication and Interaction with Infants and Toddlers?	309

Health, Mental Health, and Resiliency

Biological and Environmental Factors that Influence Child Development	313
Community Child Health in the 1990s: Integrating Community Child Health, Part I	326
Community Child Health in the 1990s: Head Start and Managed Care — The Minnesota Experience, Part II	336

Health and Safety in Head Start	344
Children in Context: Effects of Family and Child Care Stressors on Preschoolers' Physical and Mental Health	347
Research Perspectives on Community Partnerships for Effective Inclusion, Part I	352
Inclusion of Children with Special Needs in Head Start: An Ecological Systems Analysis, Part II	359
Psychosocial Adversity: Risk, Resilience, and Recovery	360
The Resilient Children Making Healthy Choices Project: Translating Resiliency Research into Practice	370

Methods for Assessing Low-Income Minority Families

The Measurement of Developmental Competencies: Implications for Head Start Research	374
Issues in Developmental Research with Children and Families of Diverse Backgrounds	389
Assessing Families and Neighborhood Conditions in Hispanic Communities	400
Strengthening the Links between Research and Practice: Lessons Learned in Conducting Research on Children, Families, and Communities with Multiple Challenges	402
Methods for Head Start Research: New Developments and Recurring Issues	406

Program Evaluation

Building Bridges among Researchers, Communities, and Policymakers: The Role of Program Evaluation in Addressing the Needs of Adolescent Mothers and Their Children	419
Collaborative Approaches to the Evaluation of Family Support and Preservation Programs	423
Assessing Program Quality	427

Miscellaneous

New Directions for Minority Research in Head Start	439
Recent Foundation Initiatives to Improve the Lives of Young Children and Their Families	453
Research from Historically Black Colleges: A Poster/Symposium	465
Positive Aspects of Media on Children	472

Posters

Adolescent Mothers	485
Applications from Research in Other Countries	488
Child Care	490
Child Mental Health Issues	499
Children with Special Needs	505
Cultural and Linguistic Diversity	518
Curriculum and Classroom Practice	528
The Family in the Community	540
Family Support and Self-Sufficiency	547
Health and Nutrition	561
Infants and Toddlers	567
Literacy and the Home Learning Environment	583
Mental Health and Mental Health Interventions	598
New Approaches, Methods, and Measures	606
Normative Child Development	614
Parenting, Parent Education, and Parent Involvement	622
Professional Development	641
Social and Academic Competence	648
Stressors: Homelessness	655
Stressors: Poverty and Its Ramifications	662
Transition	668
 Appendix A: Cooperating Organizations and Program Committee	 681
Appendix B: Peer Reviewers	683
Appendix C: Subject Index	685
Appendix D: Directory of Participants	687

Special Sessions

Keynote Speaker: Edward Zigler

Sterling Professor of Psychology at Yale University

Director of The Bush Center in Child Development and Social Policy

Head of the Psychology Section of Yale's Child Study Center

Edward Zigler, Ph.D. is Sterling Professor of Psychology at Yale University, Director of The Bush Center in Child Development and Social Policy, and Head of the Psychology Section of Yale's Child Study Center. Professor Zigler was a member of the National Planning and Steering Committee of both Project Head Start and Project Follow Through. In 1970, he was named by President Nixon to become the first Director of the Office of Child Development (now the Administration on Children, Youth and Families) and Chief of the U.S. Children's Bureau. While in Washington, Dr. Zigler was responsible for administering the nation's Head Start program. As Director of OCD, he led the efforts in conceptualizing and mounting such innovative programs as Health Start, Home Start, Education for Parenthood, the Child Development Associate Program, and the Child and Family Resource Program.

Upon leaving government, Dr. Zigler continued to assist policymakers by serving on the President's Committee on Mental Retardation and, at President Ford's request, chairing the Vietnamese Children's Resettlement Advisory Group. In 1980, Zigler was called upon by President Carter to chair the Fifteenth Anniversary Head Start Committee, a body charged with plotting Head Start's future course. Recently he was a member of the Advisory Committee on Head Start Quality and Expansion, the planning committee for the Early Head Start program for families and children ages zero to three, and the Head Start Round Table of the National Research Council. He also appears with regularity as an expert witness before many Congressional committees, and is frequently called upon by the media to comment on social policy issues concerning our nation's children and families.

At Yale, Professor Zigler directs a distinguished laboratory engaged in a variety of basic and applied studies of child development and family functioning. His scholarly work cuts across the fields of mental retardation, psychopathology, intervention programs for economically disadvantaged children, and the effects of out-of-home care on the children of working parents. He headed a national committee of distinguished Americans charged with examining the possibility of making infant care leaves a reality in America, work that inspired the Family and Medical Leave Act of 1993.

Dr. Zigler received a B.S. at the University of Missouri at Kansas City and obtained his Ph.D. in Clinical Psychology from the University of Texas at Austin in 1958. He taught at the University of Missouri at Columbia for one year before going to Yale University in 1959. He has received numerous honors, including the Harold W. McGraw, Jr. Prize in Education and awards from the Joseph P. Kennedy, Jr. Foundation, the American Psychological Association for Retarded Citizens, the American Association on Mental Deficiency, the National Academy of Sciences, the American Academy of Child and Adolescent Psychiatry, the National Head Start Association, and the American Orthopsychiatric Association, where he was the 1993-94 President.

Professor Zigler is the author or editor of 25 books and has produced over 500 scholarly articles. He is a member of the editorial boards of eight professional journals.

Opening Session

Douglas Klafohn: Welcome to Head Start's 3rd National Research Conference, entitled "Making a Difference for Children, Families, and Communities: Partnerships among Researchers, Practitioners, and Families." I am the Deputy Associate Commissioner for the Head Start Bureau. Helen Taylor, our Associate Commissioner, was very much looking forward to opening this conference, but she has been ill recently and was not able to attend. She asked me to extend her sincere welcome.

The Administration for Children and Families, our umbrella agency, has emphasized partnerships—the theme of this conference, as both a major goal and as a process for providing the best services for children and families. By forming collaborative relationships that call on the varied expertise that exists within community organizations and institutions, we will provide hope and opportunity for our nation's children and families. Universities have a very important role in these partnerships. Head Start serves as a national laboratory for state-of-the-art practices and thus affords us the opportunity to conduct new research that will inform our future direction and practice.

Head Start is proud to be able to host these unique research conferences where, not only the latest research is presented, but researchers, practitioners, and policymakers have the opportunities to network and begin partnerships that benefit the children and families in our communities.

Faith Lamb Parker: I bring greetings from the Columbia University School of Public Health, the contractor for this conference. Our collaborator is the Society for Research in Child Development. I think my colleague, John Hagen, who is the Executive Officer of SRCD, would agree that we have worked hard and well together in developing all three of the Head Start national research conferences, but that we are especially proud of this one. Esther Kresh, the Federal Project Officer, was instrumental in developing the concept of national research conferences sponsored by ACYF, Head Start Bureau. Esther has been a valued partner in this endeavor.

I would like to introduce members of the Program Committee, with whom we have worked hard and long to develop this conference: Ann Bardwell, Drake University; Sue Bredekamp, NAEYC; Cynthia Garcia-Coll, Brown University, and the SRCD representative to the committee; Sarah M. Greene, the CEO of the National Head Start Association; Willie James Epps, Southern Illinois University; Gloria Johnson Powell, Harvard Medical School; John Pascoe, University of Wisconsin, Madison; Deborah Phillips, National Academy of Science; Mary Bruce Webb, Administration on Children, Youth and Families; Esther Kresh, the Administration on Children, Youth and Families; and myself.

The number of cooperating organizations for the conference has grown, from 14 national research organizations for the first conference to 44 national research and national practitioner organizations representing a wide range of disciplines at this conference. This increase in numbers and disciplines represented attests to a clear movement toward practitioner/research partnership. These diverse organizations have given freely of their expertise and time toward program development.

John Hagen: The RFP for these National Research Conferences requires the participation of an independent, professional research organization focused on issues of children and families. SRCD is proud and pleased to be this organization for this conference, as well as for the prior two conferences.

When we first began working on these conferences in 1990, we saw the main purpose as bringing researchers, policymakers, and practitioners together. With each successive conference, we have seen this happen more and more. I am pleased that so many members of SRCD and other people who are committed to research and its applications are not only attending the conference, but are getting involved in research on children and families who participate in Head Start.

For those of you who do not know, SRCD is a multidisciplinary, not-for-profit professional association with an international membership of 5,000 researchers, practitioners, and human development professionals. The purposes are to promote multidisciplinary research in the field of human development, to foster the exchange of information among scientists and other professionals of various disciplines, and to encourage applications of research findings. Our goals are pursued through a variety of programs with the cooperation and services of the governing council, standing committees, and members.

I am pleased to be able to introduce the Assistant Secretary for Children and Families in the Department of Health and Human Services, Mary Jo Bane. Secretary Bane oversees more than 60 federal programs that direct more than \$30 billion a year to meeting the needs of the nation's children and families. These programs range from Head Start to Aid to Families of Dependent Children, special programs for refugees, Native Americans, persons with developmental disabilities, and many more. Before coming to the Department of Health and Human Services, Secretary Bane served as Commissioner for the New York State Department of Social Services. For 11 years prior to that, she was a professor and director of the Malcolm Weiner Center for Social Policy at the John F. Kennedy School of Government at Harvard University. She also was a Peace Corps volunteer in Liberia.

Mary Jo Bane: Normally I would begin my remarks on occasions like this by saying how happy I am to be here. I am actually sad to be here in this role, because the reason I am here is that Helen Taylor is not. I will do my best to be a substitute for her, but I know I cannot really do that. Actually, I am delighted to be here and to be part of this enterprise. It is an exciting conference and you have an exciting program.

My personal ties to Head Start research date back a long time. I was an editor of the Harvard Educational Review when we published a critique of the Westinghouse study. I then worked on one of the early evaluations of Head Start and did research on the planned variation experiment. So I have had a long tie to Head Start research and am very aware of its importance. It seems clear that research has been crucially tied to Head Start over its entire history. Research has been important in continuing to show that the program is effective in the short term and in the long term. It also has been crucially important over the years in helping to improve the program, to identify those features of Head Start that are most important in bringing about effective programming.

When I came back to Head Start, I was disappointed that there seemed to have been a period when Head Start research was not as vibrant and effective as I believe a lot of us would have liked. Therefore, I was pleased when I had the opportunity to chair the Advisory Panel on Head Start Quality and Expansion, where we were able to talk about the importance of building knowledge and continuing the commitment of Head Start to knowledge development and improved programming through research. These are huge challenges for Head Start as we move into the 21st century. The challenge now is to be a leader and a model of excellent programs for young children, in order for Head Start to genuinely become a centerpiece of community efforts to improve the lives of children and their families. Head Start cannot be isolated. It cannot simply do an

Opening Session

excellent job of serving children, but, we must, in fact, reach out and be a model for communities. We know something about how to do that, but I do not think we know nearly enough. One of our challenges as researchers and practitioners over the next few years will be to develop that vision.

In the Advisory Committee deliberations and the legislation that followed, we also had a chance to put in place an exciting new program as part of Head Start, the Early Head Start program, which focuses on very young children and recognizes that the earlier we begin delivering services to young children and their families, the more likely there are to be good outcomes. This is another big challenge: to develop those programs, to evaluate them, to learn from them, and to continue to improve them, so that we can fulfill that promise of the Head Start vision.

Therefore, this conference is faced with a big challenge: the challenge of recognizing and responding to the issues that are facing Head Start as it moves into the 21st century, of designing ways of working together to build knowledge so that Head Start can continue to improve and meet its goals. One of the things that is so exciting about this conference is that it does bring together researchers, practitioners, and even bureaucrats. That does not usually happen. It is relatively unusual for there to be close collaborations between people who are running programs and people who are doing research on them. Obviously, these are extraordinarily fruitful collaborations with enormous promise.

My role is to introduce the keynote speaker, Dr. Edward Zigler. I could introduce him by recounting the accomplishments in his long and illustrious career. Those are listed, however, in the biographical sketch in your program. What I would like to do instead is to talk about some of the contributions that are not listed in a formal biography.

Today, more than at any other time, we acknowledge the importance of fathers in children's lives. Perhaps we recognize that importance because we know that so many children grow up without the guidance and love of a father. Head Start was fortunate. In the 31 years of its existence it has always had fatherly love, guidance, and support from Edward Zigler. He was there not only from Head Start's conception, but he helped with its birth. He was there during the years that it was growing up. As the good father that he is, Ed was there to praise Head Start when it did well, protect, nourish, and encourage it during dangerous times, and admonish and correct it when he did not think that right things were going on. Whatever fatherly love might be, it was always undertaken with unwavering and unconditional love. Finally, after the child had reached full maturity, Ed was proudly there to assist with the birth of, and to welcome, the new generation, Early Head Start.

In recognition and gratitude for a father's strength, guidance, and support, I would like to present Ed with this plaque on behalf of Head Start and all the conference attendees: "To the true father of Head Start. You have raised this child well."

Edward Zigler: We have come a long way, many of us together. For my formal presentation, let me take you back to that spring preceding the first summer of Head Start. Believe it or not, there was a debate among the planning committee as to whether we should have any research at all. Some of my colleagues common-sensically argued, what is there to research? What is there to evaluate? We are going to give children a wonderful six-week experience. We are going to feed them. There is nothing here to look at. I thought we should have research; however, it fell to my mentor Julie Richmond to finally make the decision. Julie was wise and said yes, we will have a research component in Head Start. You in this audience are the heirs to that decision.

Head Start has been an integral part of my life for many years. This is true for many of you here today. We are all interested enough to interrupt our busy lives to travel here this week to learn what there is to know about the program. Today, I am going to praise all of us for what we have done for Head Start, both in our individual roles and professional groups. However, I am also going to admonish all of us for what we have failed to do to keep our program strong.

Many positive developments have occurred since we met here last. Today, there is a renewed vision of Head Start as a national laboratory for the design of effective interventions. Research is essential to the Head Start effort, and all of us have a stake in its conduct. The new Early Head Start is a shining example of how good research can build a sound knowledge base that can guide the development of promising solutions. Yet research has often failed Head Start, both in its substance and in its lacunae. Investigators have too often looked in the wrong places, too casually generalized from other programs, and have failed to ask the tough questions. Practitioners, understandingly sensitive to the public criticisms and funding threats that plague Head Start, have often shut the door on researchers. You may have done so to prevent us from finding something wrong, but you also prevented us from seeing much that is right. Policymakers have been fair-weather friends, lavishing or withdrawing support depending on the morning headlines.

I do not mean to sound unduly harsh. I am probably one of the country's oldest Head Starters, so I can truly appreciate all that you have done. The scholars among us have fought long and hard for a more organized approach to Head Start research. Our persistence has finally paid off in the form of the Research Centers on Head Start Quality that were recently established. Practitioners have faced a lot of hurdles and still managed to improve the quality of life for 750,000 poor children and their families this year alone. Policymakers just fought a prolonged budget war and somehow emerged with Head Start's funds intact. So, if at times I sound as if I am taking you to task, please keep in mind that I am grateful for your hard work, even as I ask you to do better.

My first remarks will be directed toward the students and researchers here, not so much because they are in the majority but because I am one of them. I have been at this a lot longer than most of you have, so I share much of the responsibility for our shortcomings. Research has played a central role in the Head Start story, and too often that role has been of the villain. The part was cast in the very early days of the program, when we discovered that early intervention had an immediate effect on children's IQ scores. It is exciting to do research that produces such positive and desirable results, so we flocked to Head Start centers with our WISC and Stanford-Binet kits in hand. Our focus on cognitive benefits created popular expectations that Head Start existed to raise children's measured intelligence. When the infamous Westinghouse Report delivered the unwelcome news that the achievement gains children made in preschool were short-lived, Head Start was nearly dismantled. To this day, many dismiss Head Start as a failure because it does not permanently give children more coveted IQ points.

Our zest for studying cognitive benefits created a research tradition that has been very hard to break. By carrying on that tradition, we have neglected to look for benefits in other important areas. We all know that Head Start is a comprehensive services, two-generation program. Yet our studies have targeted the preschool education component at the expense of the other program features. For example, the health component is arguably the most successful part of Head Start. Head Start is the largest single deliverer of health services to poor preschoolers in this country. So why do we know more about changes in their IQ scores than about changes in their health and immunization status? Head Start also has vibrant parent involvement and social service compo-

Opening Session

nents, but there has been very little systematic work to determine the program's impact on families. Does their quality of life improve? Do they develop better relationships with their children? Do they learn to parent more successfully? Are Head Start parents less likely to engage in child abuse and neglect? Do Head Start parents space their children in a manner conducive to optimal development? That this might happen is suggested by the Provence project, which found births among poor mothers cut by half. I have a hunch, and it will take your good work to bear me out, that parents become better socializers of all their children because of their involvement in Head Start. The possibility of diffusion effects to siblings means that the benefits of Head Start might be a lot broader and more important than anything cognitive tests will ever show us. Again, in an evaluation of the Provence intervention, Victoria Seitz found that siblings of the target children displayed superior performance to siblings in the comparison group. And so, fellow researchers, it is time to take the road less traveled.

Not only have we looked for the possibilities of Head Start in the wrong places, but we have looked in the wrong time frame. Head Start's primary goal is, and always was, to prepare children for school. This short-term goal was too modest for the optimistic times when the program was born. When President Johnson introduced Head Start in a speech in the Rose Garden, he quickly moved from school readiness to the long-term dream of breaking the cycle of poverty. At the time, Head Start was only a summer program lasting six or eight weeks, but it was supposed to magically inoculate children against poverty for the rest of their lives. The optimistic 60s are long over, but we have been unwilling to let this dream die. To this day, many very smart people continue to believe that a brief preschool experience can guarantee children high school diplomas, good jobs, and clean criminal records. This is the same as believing that if we are wonderful parents for just one year, our children will turn out wonderful, and we will never have to parent again.

Our pursuit of lifetime benefits has created some very serious problems for Head Start and the entire field of early childhood intervention. First, when we set expectations far too high, our programs are bound to fail. People become disappointed and are reluctant to support early intervention in principle. Worse, they may give up all hope that helping poor children succeed is even possible. Second, by looking too far into the future, we have overlooked the immediate benefits of attending preschool. Hundreds of studies have now proved that Head Start is very successful in preparing children for school. Not only do they acquire the skills and concepts necessary for school readiness, but their health status improves, they receive dental care and glasses if they need them, they acquire social skills, and their parents learn to be involved in their children's education. These are no small accomplishments. So I am asking you to change your line of thinking. Let us agree that school readiness is a worthwhile and attainable goal. Measured by this criteria, Head Start is a smashing success.

We do not have a lot of longitudinal data to show us if Head Start graduates achieve better throughout their years of school. However, some fade-out should not surprise us. Lee and Loeb presented some distressing evidence that Head Start children are likely to attend poor-quality schools, which does not bode well for their educational success. However, I for one am not about to accept the reality of total fade-out. For an excellent recent review of the benefits of early intervention, I refer you to the entire issue of the Packard Foundation's Winter 1995 publication, *The Future of Children*.

If fade-out does not always occur, does this mean that Head Start can have lasting benefits? Perhaps, but not single-handedly. To the extent that it impacts families, it may very well improve the child's family environment and developmental outcome. It is most likely to succeed if the

preschool program is of high quality and is flanked by dovetailed services that follow the family from early in the child's life through the first years of a good elementary school. This is a hunch derived from the findings of similar programs such as the Chicago Child-Parent Centers. As researchers, we have been trained to build hypotheses from the insights of related work and to determine the generalizability of findings through careful study. Most unfortunately, these are skills that we have too often failed to apply. Instead, we have shamelessly borrowed from other projects results that we like, bestowed them on Head Start, and proceeded as if we know more about the program's efficacy than we actually do.

An embarrassing example is the statement that for every dollar spent on Head Start, taxpayers save \$7 in reduced educational, welfare, and criminal justice expenses and greater earning power. This statement has been repeated so often that it has become common knowledge. We all know where these findings came from, and they are not from Head Start but from the Perry Preschool Project. Evaluations of no other program have followed preschool graduates for so long, included so many outcome measures, and conducted such intricate cost/benefit analyses. Yet many have casually applied these findings to Head Start, fooling ourselves, the public, and even some United States presidents into believing that the program has been proven cost-effective. I am not saying that Head Start is not cost-effective. I believe that it is extremely cost-effective when services are of high quality, but we have little hard data to prove this.

Borrowing results from the Perry Preschool is neither scientifically honest nor politically wise. Those who discover the scam are quick to think that we are hiding something, that Head Start's effects do not justify the expense. If we had not pilfered the evidence, they might more reasonably advise us to do some of our own cost/benefit analyses to help them determine if Head Start is worth the investment. We must never again justify Head Start by equating it with other programs, no matter how much we covet their results. There is no reason to believe that high-quality Head Start programs do not produce the same or even better results. Our task is to find out.

One reason why we may be too quick to adopt the findings of other programs is that they are more current than what we have available for Head Start. A common complaint I hear about Head Start research is that much of it is old. That may be true, but the Head Start research funding well went dry during the 1980s, and we missed an entire decade of work. In addition, let us not be so quick to dismiss studies just because they are old. Remember that he or she who does not know history is destined to repeat it. We have volumes of old studies that show Head Start produces immediate gains in children's IQ scores. Let us say this is now a fact and go on to something else. I do understand the complaint that older work was conducted during a different social era and might not be applicable to children born in the 1990s. This is a genuine concern, but why is it only directed toward Head Start research? Does anyone remember that the Perry Preschool ceased operating in 1967? The Abecedarian Project involved children born between 1972 and 1977. Longitudinal work, of course, requires time between the treatment and the eventual outcome. We cannot attend only to the recently published outcome data and dismiss the initial program reports because they are old. They are the baseline. We can also spend more time in the library searching for more current, if lesser known work. The Chicago Child-Parent Centers, for example, are larger than the venerable model projects, are much more like Head Start, and are still ongoing.

Critics are skeptical of Head Start not only because of our failure to investigate so many important questions, but because they believe the quality of our work leaves much to be desired. There has been a massive amount of research on Head Start, and yes, some of it is not very good.

Opening Session

Head Start programs and populations vary tremendously, and eligibility rules preclude random assignment. The program is so hard to evaluate that in the early days some wondered if we should even try. But try we did, and we created an entire literature. That literature has built a solid knowledge base about the principles of effective intervention. As our theories and methodology have grown more sophisticated, so too has our ability to apply scientific knowledge to shaping programs that work. All of this was possible because Head Start is not just a program a group of experts designed long ago, but it is a laboratory where we all work. In this lab we have invented many products, such as the Parent and Child Centers, Home Start, the Child and Family Research Program, the Comprehensive Child Development Centers, Education for Parenthood, CDA training, Family Service Centers, Early Head Start, and the Head Start Transition Project. We have conducted enough experiments in our lab to delineate what effective intervention must entail. Today, it is common knowledge that good programs must be two-generation, provide comprehensive services, and last long enough to make a difference. Head Start pioneered these methods, and our research has vindicated them and enlightened a new discipline.

The final comment that I will make concerning the activities of researchers is about how we make use of our findings. I am not referring to the value of basic versus applied work, for I have long argued that the distinction is a questionable one and that both are needed in the research enterprise. What I am referring to is how we communicate our findings to the Head Start community. Here I am going to borrow from something very old. Well, it is not the Torah or Ten Commandments, rather it is George Miller's presidential address to the American Psychological Association in 1969. He implored us to give psychology away. He argued that our work is not some esoteric branch of witchcraft only Ph.D.s can practice, but is something that can be used by all. This education, he said, should be fitted to the needs of the people who receive it. This can be easier said than done, particularly for those doing basic work. However, it is absolutely essential to the science that we help nonresearchers understand the substance of what we are doing. We cannot beg for permission to test at a Head Start center, disrupt their schedule for a few days or weeks, and never return with an explanation of what we found and how it might be useful. No wonder practitioners shut the door on the next researcher who comes knocking. We must do more to establish good working relationships with our Head Start colleagues.

Now I will address the practitioners in the audience. I have no harsh words for you like those I just had for the researchers. You are confronted with so many barriers, work at such a difficult job with so little pay, and give so much to children and families that it would be hard to raise a furrowed brow at you. My remarks will center not on what you do, for you are doing a wonderful job. I will instead focus on what I see as a defensive stance that has become firmly entrenched in Head Start centers. I understand why it developed, but I also understand that it can do Head Start a lot more harm than good. Head Start has always led a precarious existence. It has been threatened with termination or downsizing so often that it is hard not to be defensive. In addition, critics have continually done their number on Head Start, blaming you for everything from not making children into geniuses to failing to assure that their parents no longer need welfare. The fact that so many unattainable expectations have been held for Head Start sets you up for failure. You have also been entrusted with serving the most vulnerable children and families. You have never been given enough resources to deliver high-quality services to them. None of this is your fault; however, not all criticisms are undeserved, and many of them are constructive.

Consider, for example, the rash of friendly criticisms that spread during the last wave of expansion. Not all programs were delivering mandated health services, making good-faith efforts to involve parents, or properly monitoring their finances. These accusations must have hurt, but

they also paved the way for the Advisory Committee on Head Start Quality and Expansion and encouraged policymakers to preserve the funds set aside for quality improvements. In the last 2 years, more bad Head Start programs have had their grants pulled than in the first 30 years of Head Start combined. This should not frighten you. When the bad apples are removed, the shine of the good ones is easier to see. I have worked with every administration since the Johnson years on Head Start issues. We are all familiar with President and Mrs. Clinton's commendable commitment to the Head Start program. Without question, this administration has produced the most effective Head Start warriors that I have seen in 30 years. It has taken courage, ability, and hard work to improve the quality of Head Start nationally and to mount the exciting Early Head Start initiative. We should all be grateful for Health and Human Service's current Head Start family, and I would like to personally thank Donna Shalala, Mary Jo Bane, Olivia Golden, and Helen Taylor.

As for your cooperation in research, I understand that it can be hard to endure the disruption for projects that have no apparent value to you. However, we must think more in community terms. The future of early childhood intervention depends on research. Without it, as we have seen, people come to believe that it is not worth the cost. Not only will research help justify our existence, but it can eventually point the way to better services and approaches. I have never considered Head Start to be a static program but an evolving concept. It has demonstrated innovative ways to serve children and meet diverse family needs. Donald Campbell once said that we can only develop better programs if we become advocates for the problem, not for a particular solution. If helping at-risk children succeed is the problem, then we do not have to become defensive about the solution. We will take Don Campbell's advice to be an experimenting society and continue mounting efforts and fine-tuning them in order to become ever more successful. You have a great deal to contribute to the effort and should see yourselves as full partners in it.

Policymakers are the last group on my agenda. You are so used to hearing complaints that I do not have to offer any to jar you into doing what needs to be done. Despite some threats since the last election, you have done fairly well for Head Start. I would have liked to have seen a budget that kept up with inflation and would have allowed more poor children the opportunity to attend. Since quality improvement funds are tied to annual increases, maybe such funds can be moved from a set-aside to a permanent line item. However, Head Start at least fared better than many other programs. I was particularly happy to see funding for the new Head Start Fellows program, which will train leaders to guide the program's future. In addition, all of us here thank you for the Research Centers on Head Start Quality that will answer a lot of questions and guide future policies for early intervention.

Of course, you know that I am going to ask for more. Not all of it involves funding. First, I ask that you do not expect miracles from Head Start or any other early childhood program. We cannot turn all children into geniuses or end welfare as we know it by a half-day, eight-month program. We can help children enter school ready to learn. We quite possibly can have an impact on their later adjustment in life and on their families, but do not insist on this unless other supports are in place. This brings me to a request that does require money. We need a commitment to funding research that will not run out with a change in administration or political bandwagon. Without such a commitment, we will get more of the hodge-podge of studies that do not build upon one another, the years of gaps, and the incomplete knowledge base that characterizes Head Start research today. With such a commitment, we will gain research that can inspire the construction of meaningful policies for at-risk children and families. The Research Roundtable,

Opening Session

which has been meeting for two years under the inspired leadership of Sheldon White, has provided both ACYF and the research community a commendable and far-reaching research agenda.

My 30-year-plus journey in Head Start has been an exhilarating one, and I am grateful for having had the opportunity to be so close to this wonderful program. I have been its champion when I could and its critic when my love of Head Start children said I must. It is a journey that has had its ups and downs, but allow me to note a constant: For three decades, I have asked scholars in academia, Head Start practitioners, and policymakers, many in this room, for their help on one Head Start effort or another. You have all proven discerning and caring colleagues. Working together we have improved the quality of the lives of 14 million impoverished children and their families. We have all worked hard, and we should be proud. So allow me to congratulate and thank each and every one of you for the help you have given me.

Audience Questions and Comments

Larry Schweinhart: I would like to clarify how we agree and how we do not agree. First, I want to address the relationship between short-term and long-term outcomes. Part of the reason it is so hard to define school readiness is because it is incremental. It leads to long-term things, or it ought to. It seems to me that one of the best ways to think of the relationship is that long-term outcomes could serve well as a guide to short-term outcomes, and help us to further clarify what those short-term outcomes ought to be.

Second, it is wise to distinguish between the High Scope Perry Preschool program and Head Start, but by the same token, I do not want us to fall into the "Perry on a pedestal" problem. Perry was run by real flesh-and-blood people dealing with a real political situation and with their own capacities to deal with that situation. Those people were not different from you or me. I would hope that we could try to find the areas of generalizability and build bridges and roads from the Perry Project to Head Start rather than to simply look at walls that we erect between them.

Edward Zigler: Thank you, Larry. For your information, I wrote a piece that is in the *Early Childhood Research Quarterly*, entitled, "Is the Perry Preschool Better Than Head Start? Yes and No," because I think there has been a mistake made in this country, and a serious one in which Perry Preschool is like the gold standard and Head Start is something less. I do not believe that. The "yes" is about the magnificent job Perry has done in the long-term study and evaluation of their program. Some other features: they pay their teachers a lot more and Perry Preschool costs twice as much as Head Start in concrete dollars. However, let me inform my friends from Ypsilanti that the Perry Preschool was not a model of what early intervention should be. They had no health services or social services. Their approach to families was not the approach of Head Start in that they did not involve parents in the running of their program.

In terms of everything I know about early intervention, Head Start is much more a model program than the pioneering effort at Ypsilanti. The problem is that we did not have the wisdom of long-term evaluation that is so necessary. If you look at it logically, since Head Start is by far the richer program of the two, we should be able to find exactly the effects found by Perry Preschool and, hopefully, even more. So we will continue to coexist, but in my mind, in terms of a model program, I prefer Head Start over Perry Preschool.

Thomas Caffrey: How do you build a research mentality that spans 20, 30, and 40 years of a child's development within a political environment in which persons are elected for 2, 4, or 6 years at most, and gauge their decisions according to those election rhythms?

Edward Zigler: We have a task for policymakers, practitioners, and researchers. The optimal development of poor children at various points has been a bipartisan effort. If we present Head Start properly, we can have the continuous and constant support that is needed to do the kind of 30-year effort that you are talking about. However, let me give you a warning about why that will be difficult, and is difficult, today. I refer you to the piece by Hood from the Cato Institute entitled "The Head Start Scam." I wrote a rebuttal to that piece. Head Start, for all of its ups and downs, has a very special place in the hearts of Americans. For those on the far right this is problematic. We have all read Charles Murray's "Losing Ground." Their ideology is such that no program works. Not only does no program work, but they feel that we make the situation that we are trying to solve worse. Head Start is a beacon that they would like to put out, because it is too popular. It gives people the idea that maybe government can indeed do something that is beneficial to our most worthy and needy children. So the political battles are not going to end, no matter what we say today. What we have to do, and what researchers have to do, is make a good clean case for what this program accomplishes, honestly make it seem so valuable that no matter what future administrations or political ideologies come along, Head Start will always be safe. The research done within Head Start, since it is such an integral part, will also be safe.

Mary Fulbright: I would like to add a thought to your comments. While the political scene changes, we should also include in the Head Start partnership major businesses. They have a vested interest in the success of Head Start. Their future depends on Head Start to a great extent because it depends on a good labor force. If we can include business as collaborative partners, it is possible that those companies can be bridges for us regardless of which political party is in power at a given time. By doing that, we can mitigate the gap that occurs from one administration to the other. Business can have a major impact by providing us with funding that can be supplemental to governmental funding.

Edward Zigler: That is a good point, well worth making. What I want from business is their advocacy for Head Start. Business has a special voice in this town and in this country. Businessmen are smarter than many in terms of the concept of investing in human capital. This is second nature to a wise businessman. Invest in that product early on. Our products are human beings. You do not start quality control at age five or six; you start it when they are born. So I could not agree more. They understand what we are about. To nurture them as allies is an important effort worth our time; we should all engage in it.

Art Frankel: I was a project evaluator for the Family Service Centers in Philadelphia. One of the things that struck me as I watched Head Start Family Service workers and other coordinators work over the three years of the evaluation, both in the experimental and the control groups, was the amazing amount of work that they did with families. This work was largely undocumented in the existing Head Start record-keeping system. Therefore, it was difficult to get process and product data from the Head Start program. I am wondering if you have any comments on the existing record-keeping systems in Head Start?

Opening Session

Edward Zigler: One of the quality issues has always been the management of information in the Head Start program. It has been a problem for a long time, including the days when I was responsible for Head Start. How can you evaluate anything unless you have nailed down what your treatment is? One of the reasons that this conference is taking place is that it gives you a forum for making these kinds of remarks, so that the people responsible for Head Start can have in their information system and in their routine data collection the kind of information that is so necessary to researchers.

Marlynn Levin: I am from the Merrill-Palmer Institute. What I would hope is that the research might give some substance to the concepts of Head Start, and that these concepts continue into the public school life of children. Much of what is gained during the preschool years is often lost in the public school forum because they are not continuing a lot of the excellent concepts.

Edward Zigler: You are preaching my sermon. I remember I started a project when I was in Head Start 25 years ago called Project Developmental Continuity. It is time that we give up forever the inoculation model of human development. Think of a developmental model. It is not complicated. Your children lived it; you lived it. At each stage of development, human beings need certain environmental nutrients for optimal development. They need them in the first three years of life. They move on to another stage and they need a new set of environmental nutrients.

I just attended an impressive conference in Chicago on the development of the brain in which our colleagues in the brain sciences point out there is this wonderful plastic period from birth to age 10. We were not so wrong back in the early days when we started the child and family resource programs and I insisted it had to be a program from ages zero to eight. Therefore, do not wait for a child to be three; get in there earlier. Then do something in the preschool period and follow up the child in school. I made this pitch in my newest book, called *Head Start and Beyond*. I have been making it for 25 years and I have not been heard yet. However, we do have the Transition Project. They are following Head Start children with exactly the same services from kindergarten through the third grade.

Sandra Owen: It would be a fair assumption to say that all of us who love, represent, and work with Head Start believe that parents and family members are the child's first and best educators. Most of my early experience has been in the alcohol- and drug-prevention model. From that experience, I soon understood that family members, when given the opportunity, can become powerful political advocates for the welfare and health of their children. What wisdom do you have for us about how we might better help parents to become political advocates?

Edward Zigler: The first step is to have parents involved in Head Start join the National Head Start Association. One quick story: Back during the Carter years, President Carter was very friendly to Head Start, but a deal had been cut to move Head Start to the Department of Education, which meant that it would become a bloc-granted program to the states. The senator who was chairing that committee was Senator Ribicoff. I cajoled, begged, and argued with him. Marian Wright Edelman had already testified. Senator Ribicoff said to me, "I am just carrying the President's water on this. There is no way you can change my vote." Two weeks later a group of Head Start parents, mostly unschooled women, got on buses in Hartford and New Haven, CT, and traveled all night to Washington D.C., sat in Senator Ribicoff's office (for they were his con-

stituents), and convinced him to change his vote. The vote was 14 to nothing to keep Head Start out of the bloc grant. Therefore, I know the power of parents, and I am grateful to the National Head Start Association, which gives them a home and an organized forum.

Question: You identified Head Start as the gatekeeper to the delivery of care to 14 million disadvantaged children. What do you perceive as the main categories of barriers to delivering medical care to these children?

Edward Zigler: It has to be done community by community. We have spent a lot of effort on the health care of these children. We have never gotten the credit we deserve for this, but it is absolutely essential. That is why you cannot just worry about Head Start. We get a lot of money through Medicaid. Keeping Medicaid available is a task that we all have to engage in. You have to keep fighting these battles. The vicissitudes of political events impact our lives, and they impact the quality of Head Start. Clearly, if we do not have good health care, if we cannot broker that health care with available community resources and programs like Medicaid, then Head Start and its quality will suffer.

Opening Night Reception

Welcoming Remarks: Ann Rosewater

Deputy Assistant Secretary for Policy and External Affairs
Administration for Children and Families
Department of Health and Human Services

Ann Rosewater is the Deputy Assistant Secretary for Policy and External Affairs in the Administration for Children and Families, Department of Health and Human Services. As Deputy Assistant Secretary, she has major management and policymaking responsibilities in ACF, the agency that brings together the broad range of over 60 federal programs addressing the needs of children and families. These programs include Head Start, Aid to Families with Dependent Children, Child Support Enforcement, refugee, Native American, and developmental disability programs, the Community Services, Social Services, and Low Income Home Energy Assistance block grants, and the Family Preservation Family Support Services program.

Rosewater assisted in the creation of the U.S. House of Representatives Select Committee on Children, Youth and Families, and served as its staff director and deputy staff director for seven years. From 1979-83, she served as senior legislative assistant to Congressman George Miller (CA). During the 1970s she was national education staff for the Children's Defense Fund and assistant to the vice president of the National Urban Coalition. Immediately before coming to ACF, Rosewater was a senior associate at the Chaplin Hall Center for Children at the University of Chicago. She also served as a senior consultant to the Pew Charitable Trusts' Children's Initiative, as well as the Casey, Ford, and Rockefeller Foundations' urban change initiative, and former President Jimmy Carter's Atlanta Project.

Rosewater was the first non-elected official to receive the Leadership in Human Services Award of the American Public Welfare Association, and she received the President's Certificate for Outstanding Service from the American Academy of Pediatrics. She has served as a national board member of the Jewish Fund for Justice, the Family Resource Coalition, and the Youth Law Center. She was a member of the Georgians for Children board of directors, as well as a number of other national and local advisory boards. She has written extensively on child health and education, disabled children, child and family policy, and comprehensive strategies to reduce urban poverty.

Rosewater earned her Master's degree in the History of Art at Columbia University and her Bachelor of Arts degree "with distinction" at Wellesley College.

Ann Rosewater: Thank you for giving me the opportunity to come and join you at what is obviously a delightful and important event. I was quite thrilled when I saw that Faith was involved in this—that it was so lucky that we were re-meeting in this environment. There are so many other friends here—too many to mention—but I do want to acknowledge that Ed Zigler's leadership and devotion, exhibited in his opening address and his contribution to both Head Start and research about Head Start, are unparalleled. Sarah Greene, of course, representing the Head Start community, also has made an enormous contribution, and I appreciated her warm welcome just before I walked up to the podium. Let me also mention and thank one of the Administration for Children and Families staff who has done so much for so many years to insure that this conference and Head Start research continues to receive attention and participation by a diverse and exciting group of people. That person is Esther Kresh.

Earlier today I had the opportunity to listen to President Bill Clinton talk passionately about the importance of ensuring parents' success, both at work and at home. What he said in many dif-

ferent ways was that if we ensure parents' success at work but not at home—why do the work? If we ensure success at home, but not at work, we cannot ensure success at home. Therefore, he sees these issues of protecting children, ensuring their healthy development, and ensuring economic opportunity for parents, and parents' opportunity to raise their children in a vital and resilient way as paramount to this Administration's vision.

Head Start has much to contribute to that vision and has already a long tradition of doing so. So do the many other accomplishments of this Administration: earned income tax credit, which the President referred to today as the family tax credit; The Family Medical Leave Act; and investment in child care. There are many ways in which the Administration is attempting to put families and work and children's development high on the nation's agenda. Ensuring that we nurture the kinds of initiatives and investments in opportunities for children and families is a key element of this agenda. However, developing knowledge and understanding of what children need, and of what families need, in order to thrive, is critical to making sure that that agenda succeeds.

What you have done in this conference is to bring people together in an exciting way. I was completely "blown away" when I was looking at the program and saw the incredible combinations of researchers, practitioners, foundation leadership, and families, all coming together to try and determine not only what the important researchable questions are, but also how to think about ways of finding answers that respect all of the parties in that dialogue. That is a very challenging thing to do, but an enormously important thing to do as well.

The Administration and the Administration for Children and Families is committed to forging partnerships. We are seeking to do it in a variety of ways, and I am sure you heard about this both from Mary Jo Bane and Olivia Golden earlier today. In your daily work, I am sure you hear from Helen Taylor, as well, about those efforts. I want to convey just how dedicated we are to ensuring that there is both knowledge building and learning, as well as service, and how central it is to us to bring those together. We will continue to rely on you to help us forge those alliances and pursue what we need to learn. Another critical feature is how to apply what we learn to policy, how we ensure the translation of learning into practice. There is a lot going on in the environment that is resisting this approach, and resisting the answers that you are finding or the knowledge that is being generated. Therefore, I urge you not to get too discouraged. We all need to support each other in the knowledge that the work you are doing, the dedication you have to children and families—improving their opportunities and their lives—is the most important work that anyone can do in this nation. I applaud you for that and thank you again for honoring me with the opportunity to join you today.

Luncheon I

Keynote Speaker: Olivia A. Golden

Commissioner, Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services

Olivia Golden was sworn in as the Department of Health and Human Services' (HHS) Commissioner on Children, Youth and Families on November 22, 1993. She heads the Administration on Children, Youth and Families, located in the Administration for Children and Families. As a Commissioner, Dr. Golden oversees a budget of approximately \$9 billion. The Administration on Children, Youth and Families includes Head Start, the Children's Bureau, the Family and Youth Services Bureau, the National Center on Child Abuse and Neglect, and the Child Care Bureau.

Before coming to HHS, Dr. Golden was director of programs and policy for the Children's Defense Fund in Washington, D.C., where she was responsible for policy development, advocacy, research, and writing across the range of children's issues: health, income, child care, child welfare, adolescent pregnancy prevention, youth development, and integrated services to children and families. She was a lecturer in public policy at Harvard University's Kennedy School of Government from 1987-91, focusing on child and family policy, employment and training, and public management. From 1983-85, she served as a budget director for the Massachusetts Executive Office of Human Services, overseeing a budget of more than \$3 million. She has also been a candidate for the Massachusetts State Senate and has chaired the Advisory Committee on Children and Youth for the city of Cambridge, MA.

*Dr. Golden has written on policy and management issues concerning children and their families, including a book, *Poor Children and Welfare Reform* (Auburn House Press, 1992), and numerous papers and articles. Her research has focused on the way services work for children and families, including issues of innovation, collaboration, and effective service delivery.*

She holds a Ph.D. and a Master's Degree in Public Policy from the Kennedy School of Government, Harvard University. She also holds a Bachelor of Arts Degree in Philosophy and Government from Harvard University.

Olivia Golden: I am especially pleased to be here at Head Start's Third National Research Conference to see and hear the intensity of debate about ideas and the ferment that is here, because this conference is a special occasion since Head Start is a child of research. When President Johnson declared the war on poverty, it was research that told us that, for children who come from impoverished homes, we need to start earlier than a child's entry into school to help those children succeed. It was research that told us that, in addition to fostering a child's cognitive ability, we needed to pay attention to the child's health, social and emotional development, and family in order to have the real effects we want to have. It was research that made Head Start one of the pioneers of inclusion of children with disabilities and that helped keep Head Start safe from the partisan disputes of the last two years, as a bipartisan consensus was forged by researchers and practitioners working together on the Advisory Committee on Head Start Quality and Expansion and as that consensus held firm through all the budget wars and block grant debates. Most recently, it was research that told us how important cognitive development is in the first months and years of life and research that led the President and Congress to create the newest aspect of Head Start's national laboratory role, Early Head Start for infants and toddlers.

All of you who are researchers are part of a proud tradition that has shaped Head Start from the beginning. All of you who are practitioners, who in your daily lives are doing the work of Head Start, of child care, of serving low-income children and families, have come here to share your insights and ideas about the newest research. You are part of that tradition as well. The theme of this conference, the idea of partnerships among researchers, practitioners, and policy-makers, is woven into Head Start history as well. I have been on both sides of the fence, as researcher and practitioner, and the way I think about it is that researchers know how to do research, but only practitioners really understand how to use it. The people who have served Head Start the best are masters of both, like Dr. Zigler, who has served Head Start through his ability to go back and forth between an extraordinary academic career and a keen practical and strategic sense. Ed told me that one of the ways he had saved Head Start from the pressures of that era was to keep it a constant hotbed of innovation. He constantly took advantage of the newest research to make sure that there was always something exciting and innovative going on. In that way, no one could ever pin Head Start down or say that its time was over. I have tried to learn from that during my years here, and all of you have helped me.

I am excited to be here. This is, in fact, my first Head Start research conference because the last one was in the fall of 1993, just weeks before I was confirmed as Commissioner. Therefore, I have the chance today to report to you on everything that has happened during my time as Commissioner of ACYF in the children and family arena and in the Head Start Bureau. I would like to spend a few minutes on the broad picture of accomplishments for children and families, a few minutes on Head Start itself, and then close with a special announcement that we are very happy to make today.

Let me start by looking broadly across the agenda for children and families. The President said in his State of the Union speech in February that the first challenge facing our nation is cherishing our children and strengthening America's families. His leadership in carrying out and responding to that challenge has made my job much easier and has paid off in a number of ways, beginning with the budget battles of this past year. We had twelve continuing resolutions before the Congress that finally passed. Up until the last minute, those continuing resolutions showed a 3.9% cut in Head Start. All year, as many of you know from the program side, people who were running Head Start programs were frantically trying to cope with getting a few months of money instead of a year's worth, making long-term planning hard. It is a tribute to the Head Start community that nationwide, almost without exception, we were able to maintain program quality and avoid cutting services through that difficult year. The President spoke out clearly against those cuts, and in the final budget for fiscal year '96, which was passed at the end of April (seven months into the fiscal year), Congress restored the cuts to Head Start, restoring it to its 1995 level, and even added \$36 million to make possible the expansion to Early Head Start services for infants and toddlers. In fiscal year '97, the President's budget proposal seeks to balance the budget and at the same time make clear that there must be continued investments in children and families. It reaffirms investments both in Head Start and child care. In Head Start, the proposal suggests adding almost 50,000 children to reach the level of 800,000 children served, and to stay on a path towards serving a million children by the year 2002.

There are two other accomplishments that I would like to touch on. The first is the investment made by the Congress, at the request of the Administration, in family preservation and support services. This was the first investment of federal resources in prevention in the child welfare and child abuse and neglect systems in over a decade. I am telling you about this because it reflects the same principles as Head Start. The idea of early investment and support of families is

Luncheon I

enormously important. We have worked hard with states on their use of those resources. They have used them to expand home visiting in some cases, family resource centers, and family services. We have also worked hard with states to make sure that that process is a way of bringing community people to the table. Second, I want to spend a moment on child care and the Child Care Bureau. We are proud that a year and a half ago, in January of 1995, we were able to create for the first time a Child Care Bureau in the federal government. The idea was that combining all the different fragmented funding streams that support child care would enable us to have a single powerful policy voice. We have been focusing on stimulating child care research, on fighting for resources for safe, healthy, and affordable child care, on building coalitions for healthy child care, and on stimulating partnerships, especially between Head Start and child care, including pairing the Child Care Research Forum with the Head Start Research Conference, so as many of you as possible could attend both.

Let me turn for a moment to the whirlwind of activity that has been the last two years in Head Start. It is a whirlwind that almost everyone in this room has contributed to in one way or another, but you may not know the whole picture of what has been going on. When you last met as a group at the last Head Start Research Conference in the fall of 1993, Secretary Shalala had convened a broad bipartisan advisory committee made up of researchers, practitioners, policy-makers, and others with the idea that the group would tackle the issue of Head Start quality and the future direction for Head Start. In January of 1994, the Advisory Committee produced its report. It reaffirmed the core vision of Head Start for comprehensive, high-quality services, a focus on parents, and a grounding in the community. It said that most Head Start programs across the country were providing quality services, but that some were not, and that all programs needed to provide services that met that vision. The report gave us priorities for bringing Head Start into the 21st century: quality, responsiveness to families and their emerging needs, and partnerships. Based on that report, the Administration worked closely with the bipartisan congressional leadership to develop the Head Start Reauthorization of 1994, which was passed almost unanimously by the Congress and signed into law by the President just about two years ago on May 18th, 1994.

Today we have a great deal to report on what we have been accomplishing together. I want to speak briefly about four of those accomplishments: the Head Start quality agenda, our new proposed performance standards for Head Start, the Early Head Start program, and the revitalizing of the research agenda. I will begin with Head Start quality, which I know was central to Dr. Zigler's remarks earlier today. Both the Advisory Committee and the legislation focused on a two-pronged strategy for insuring quality in every Head Start program. It is a strategy that, on the one hand, is about support, about resources that programs can spend to insure quality, to hire staff, for fixed-facility problems, or to get training. On the other hand, besides support, the strategy is a tough approach to programs that are not able to provide quality services, even after receiving support. Since October of 1993, we have carried out both pieces, implementing the support side, but also terminating 45 programs nationwide, or relinquishing their grants because they were not able to provide quality services. More than 100 have been turned around because of intensive technical assistance. The extraordinary thing from my perspective is the partnership with the Head Start community through this whole effort. The National Head Start Association emphasized the quality issue long before we did, and has been focusing both on recognizing quality programs and on making sure that the programs that are not able to carry out quality are closed. If they do not live up to the Head Start name, NHSA makes sure that those programs do not have it. We are proud of that overall accomplishment.

Second, I want to talk about our proposed performance standards for Head Start. One of the things that the Congress told us to do following on the Advisory Committee was to look at the core guidelines that define what Head Start programs do, keep what is strong in them, and update them to reflect changes in the world, in research, and in knowledge. The Congress told us to do that, and we set about doing it by talking to over 2,000 people across the country. We are proud of the proposal that we now have. The comment period ends tomorrow, so I hope many of you have already commented. The proposed standards reflect the newest research and advice of practitioners on how to make the standards easy to use. People said the existing structure was too fragmented and got in the way of a comprehensive approach, so we simplified the structure. For the first time, we have standards for services to children from birth to age three in the same document. We are aiming to get the final rule out this fall, and those of you who know the federal system know that that would set a world record. What we want is for that to be a part of the national laboratory role of Head Start. We want those standards to be a catalyst for improvements in how America serves its young children, especially its infants and toddlers, and not only within Head Start programs.

The third accomplishment that I want to talk to you about is Early Head Start. The Congress responded to both the advances in research knowledge that tell us how much happens in the first months and years of life and the advice of practitioners in Head Start parent/child programs, migrant programs, comprehensive child development programs, and others. Those practitioners know how important it is for children to have a head start in those early years of life. As a result, Congress created for the first time, in the 1994 Reauthorization, a core initiative focused on infants and toddlers. It is a way of using Head Start's national laboratory role, insuring that we would be able to provide top-quality child development and family support services to young children. In fiscal year 1995, we were able to issue 68 grants across the country and are aiming for several dozen more this year as Congress has given us an increase for that purpose. We have a top-quality, rigorous evaluation and a major investment in technical assistance. We see this as part of the national laboratory role of Head Start, taking the lessons learned and the experience gained and diffusing it to services for infants and toddlers across the country.

Finally, let me say a little about our research agenda. You can imagine that with this much going on in Head Start, in the surrounding world, and in the other programs that affect children and families, we had to implement the recommendations of the Advisory Committee report, the Blueprint, the range of advice we have been given that told us to revitalize our research agenda. We had to have a research agenda that would support a program that is diverse, constantly evolving, vital, and always changing. We needed an agenda that would help us focus nationwide on quality and results. We needed an agenda that would help us make the links to other critical issues, particularly the links across Head Start and child care, and the links to the experiences of parents, for example, in welfare reform. That meant we had to go out and create partnerships to bring a wide range of people together: partnerships with practitioners, universities, foundations, and other federal agencies that are doing related work in service delivery or that have research expertise.

A few examples: first, there is the Quality Research Center initiative that is going to help us focus on quality and results nationwide. It involves partnerships between us and local universities that themselves have partnerships with local Head Start programs. We are going to be able to do things like testing a variety of approaches to outcomes. We are now pilot-testing a parent survey, for example. We have built partnerships with child care into the mix, in that we have linked up our set of university partnerships at the quality research centers with the set of universities that

are working on child care issues in partnership with us. Second, there is the Early Head Start research agenda. Following the advice of a distinguished advisory committee that we had for the Early Head Start effort, we have been able to combine a rigorous national research design with a focus on outcomes with rich, local research studies that will help us understand exactly what is happening in service delivery in each program. Therefore, we have a top-flight national evaluator paired with equally qualified local evaluators. We have partnerships with other agencies like NICHD and NIMH to make sure our resources go as far as possible to build our links with the wisdom of those partner agencies. For example, we have invested a modest amount in NICHD's landmark infant day care study to make sure that we fully understand about the experiences of low-income children within that sample, including both their child care and Head Start experiences. Also, we have benefitted greatly from a partnership with the National Academy of Sciences spearheaded by Sheldon White, to make sure that we keep ourselves constantly informed by outside advice and input from the researcher and practitioner communities. The Roundtable that the National Academy has convened has helped us design the first-ever national study of Head Start families, which is to be awarded this month, and which is going to help us know who the families are today and how we can be responsive to their needs.

There are more partnerships that I could mention, but I want to get to one important concluding announcement before I close. A meeting that is devoted to the excitement, talent, and ferment of the Head Start enterprise, that is a celebration of leadership in the early childhood community, seemed to us the perfect opportunity to announce still another accomplishment from the work of the Advisory Committee on Head Start Quality and Expansion in the 1994 Reauthorization. Together with the Council for Early Childhood Professional Recognition, we are delighted to announce today that the 10 outstanding achievers in the field of early childhood education and family services have been selected to serve for one year as National Head Start Fellows. The Advisory Committee's vision to create a Fellows program is part of a long-term quality improvement agenda and was enacted by Congress in 1994. As far as we know, it is the first program of its kind to recognize and develop leaders in the field of early childhood. The 10 Fellows are going to be paired with nationally recognized leaders in the federal government to contribute their knowledge, energy, and perspectives to the resolution of critical issues affecting children and families. Like the White House Fellows, SRCF Fellows, and other fellowship opportunities that many of you know about, we hope that Head Start Fellows will return to their communities with insights that will help them lead even better than they have before, and to advance partnerships among practitioners, researchers, and opinion makers in the early childhood community.

I want to especially express our gratitude to Carole Phillips, the Executive Director of the Council, for the extraordinary work that the Council has done in designing and carrying forward the selection process. Many people from the selection committee are in this room: Sue Bredekamp from NAEYC and Sarah Greene from NHSA, and others. We are extremely grateful for your time. Carole and I were talking about the fact that this was a dream of being able to recognize leadership in early childhood in this way. It is a dream that has come to fruition, a dream of many people. Joan Lombardi and Helen Taylor have been talking about it and dreaming about it for years. I want to give them a special thanks for their commitment to making this kind of recognition possible.

Here are the ten members of the inaugural class: Kenneth Acquolay, Baltimore City Head Start, Maryland; Ray Anderson, Manhattan Ogden Reilly Head Start, Kansas; Maria Benigen, Agency for Child Development Head Start program, Brooklyn, New York; Carmen Bovell,

Fairfax County Public Schools, Virginia; Eva Carter, Oklahoma Association of Community Action Agencies; Eugene Gausee, Puget Sound Educational Service District, Washington State; Marilyn Hosea, Community Housing Services, California; Brigitte Rogers, Los Angeles County Office of Education, California; Susan Rohrbo, Office of the Ohio Governor; and Carolyn Yellow Robe, Fort Belknap Head Start, Harlem, Montana. We applaud an extraordinary group of people.

I had the pleasure of speaking with the First Lady of Colorado, Bea Rohmer, who was also on that selection committee. She told me that it was one of the most joyous experiences of her life to be part of that final selection session and see and hear the energy, talent, and vision of this inaugural class of Fellows. We are excited about having them selected and look forward to their arrival in September.

I want to wish all of you success in the remaining days of this conference and in the future. I want to ask you to use this conference for several purposes. Use this conference to celebrate the accomplishments that you can be proud of; the ones I have listed are, I suspect, a tiny sample of the extraordinary work that is going on by people in this room. Renew your commitment to Head Start and to the care and education of young children in low-income families and communities across America. Use this conference to build partnerships—build new ones and renew old ones—with the researchers, parents, teachers, program directors, policymakers, and anyone else who might be sitting next to you at a session or asking a question. One of the special joys of the Head Start community is that everyone in this room brings both a personal passion and a professional commitment, rigor, and honesty to your feelings about Head Start. I want to thank you for that and ask you to renew and recharge those emotions here at this conference.

Luncheon II

Keynote Speaker: Valeria Lovelace

Assistant Vice President/Director
Sesame Street Research
Children's Television Workshop

Valeria Lovelace has a Ph.D. in Social Psychology from the University of Michigan. She is currently the Assistant Vice President Director of Sesame Street Research. Dr. Lovelace is responsible for research and curriculum development for the series and is a consultant on Sesame Street-related products for the Children's Television Workshop (CTW). Dr. Lovelace has directed research for Sesame Street since 1982.

Valeria Lovelace: I would like to talk to you about a production television journey that I have been on, and I will probably continue this journey for the rest of my life. When I was thinking about how I might tell you this story, I thought about the words from George Benson's song, "The Greatest Love Of All."

...I believe the children are our future.
Treat them well and let them lead the way.
Show them all the beauty they possess inside.
Give them a sense of pride to make it easier.
Let the children's laughter remind us how it used to be.

In 1989 Sesame Street celebrated its 20th year. It was a time when we were able to look back at what we had accomplished. We were able to see students who had grown up on Sesame Street graduating from high school and college. We were able to see the children become our future. This was a great opportunity because on college campuses we were able to say that we taught some of those students their first Spanish word. We were able to sing with students, "People in the Neighborhood" and "One of these Things Is Not Like the Other." They knew all of the characters from the show.

At the same time, however, there were a number of things that were happening on college campuses and around this country that let us know that there was tremendous racial tension still brewing. There were racial epitaphs in my own University of Michigan, as well as at other schools around the country. There was a rape across the park from the Children's Television Workshop, and there was the Bensonhurst incident where an African-American boy was run down in the street and killed. All these things were happening as we were celebrating our future, what we had projected Sesame Street would accomplish.

How in the world had the children missed the message? How had they watched all that had gone on in Sesame Street in terms of acceptance of all kinds of muppets, all colors, all shapes, all kinds of people working together in this utopia that we had created, all of them interested in learning, succeeding, and helping each other? How could these same students grow up to be the people who were doing these things? We decided that we needed to do more. We had another opportunity to project into the future with more explicit messages about tolerance, acceptance, being kind. So writers, producers, and researchers got together and started to work again.

We decided to launch a four-year race relations initiative. At the beginning many of us said, maybe if we had a little potluck, and everybody brought in a few dishes from various groups, we could work this out. This did not work. We had to acknowledge that we are ignorant about each other. We do not know each other's culture. We have grown up in a society that has

not allowed us to learn what we need to know about each other. We have history books that leave off sections or rewrite things in certain ways. As researchers, producers, toy makers, and film makers, we needed time to learn.

The first year we decided to look at African-American culture. We brought in experts, did research, and tried to figure out if it is even appropriate to talk about race and culture to three, four, and five year olds. Here we are, an international program in over 80 countries, and wondered if we could be doing more harm than good. Could we be planting the seeds of hatred and intolerance by being more explicit about culture? We had an intense conversation about this.

We also had intense discussions about people in positions of power who had never experienced friendships with people of other cultures. People on our team admitted that they did not have a real friendship with a person from another culture. They admitted that when they walked down the street and three African-American teenagers approached them, they were afraid. The women admitted that they clutched their purses when they saw an African-American male walk past. No one wanted to admit that as people who wanted to produce something for the children, for the future, there were things that we had to first work through ourselves.

There is a tremendous amount of research documenting that three, four, and five year olds are very much aware: that at six months old they are aware of color, they are able to make decisions, and we are helping them understand what to value and what not to value. We did the literature review, brought in experts, and then did some research of our own. Here is a short video that was produced by the research department of Children's Television Workshop. It will give you a feel for the types of research we did with the children:

(Soundtrack from the videotape) These are the children, just a few of the children who make up our world. They are the same in many ways and different in many ways. But how do they feel about each other? Do they understand the racial differences between them? Would they use these differences to make decisions about people and their world? In our studies with these children, we found many similarities. However, we also uncovered differences that need to be addressed.

How is it possible that when asked to separate photos into two plates, one containing African-American children and the other containing White children, this Caucasian female accomplished this sorting task with ease, yet this African-American female placed photos of both African-American and White children in both plates? Research shows that race is not a factor in sorting abilities. What contributed to these differences? Across our studies both the African-American and the Caucasian children responded similarly. However, when these children were given the opportunity to structure a neighborhood by choosing pictures of African-American or White children, the majority of the five-year-old Caucasian children segregated all of the buildings, while the African-American children did not. All of the children knew that the rejected child was sad. Half of the children were able to name at least two different verbal strategies they would use when faced with a situation of rejection. Almost all of the children in the study said that they would play with the rejected child. According to the preschoolers, people who are in jail or on drugs could be either African American or White. However, the preschoolers agree that the people who are rich are White, and the President will be African American.

We want to thank these children for sharing their feelings and telling us about their experiences. We have learned a lot. Now, the question remains: Is there anything else that Sesame Street can do in the area of race relations? (end of video)

In the video there were a number of findings that are of interest, but I would like to focus on the creation of a neighborhood. That was an original study where we tried to explore what

Luncheon II

children would do if they had open possibilities to create their own neighborhood, to be able to put people where they wanted to put them, and project into the future. We now have interviewed African-American children, White children, Crow Indian children, Chinese-American children, and Puerto Rican children, and given them all this "Make A Neighborhood" game to play. What we find is that the majority of the children integrated all of the neighborhood structures: the supermarket, playground, church, schools, apartment buildings, and houses. However, by the age of five, the White children segregated every single structure. This was a developmental trend that emerged in the White children, and they only segregated African-American children.

Since this is a nonverbal measure, we did not know why the White children sorted the way they did. We wanted to understand more about that, so we went to other five-year-old White children and told them about the study that we did. We told them that we had shown these children paper dolls. Some of them had dresses, some had pants, some had long shirts, some had short, some of the children were African American, some of them were White. We told them that our first group of children had placed the White and African-American children in separate places and asked them what they thought about what the children did in the study. The White children said that the children did the right thing. They also said that the White children would feel sad, and the African-American children would feel sad. However, they felt that the children did the right thing. They said the reason why they did the right thing was because of difference. They are different colors. For economic reasons, they do not eat the same food, and they have no toys. One house is small, and one is big. The children said they separated them because of conflict. Once they get older, they might argue and hurt each other. They separated them because of existing separate housing. They do not live together; they live in separate houses. The White dolls live in the white house, and the African-American dolls live in the black house. African-American people live on one street, and White people live on another street. Then the child said he would do it for his sister. His teacher told him that African-American people live in one house, and White people live in another house. It was clear to us that the nonverbal techniques that we had observed in our research reflected something significant. Three, four, and five year olds, but basically five-year-old White children, had reasons for why they were doing what they were doing in our research.

We decided to create a segment that would show a visit between an African-American and a White child to help them understand that in this world we can live together, play together, and share communities together. We titled this segment "Visiting Ayesha." When we show it to children, no matter what the background, it is riveting. They love the segment. They also remember a lot of the activities that the children engaged in on the film. They recalled that both girls played with the African-American doll. However, after viewing the segment, only half of the children said that their mothers would be happy about them playing with an African-American child. Significantly fewer White children thought that Olivia, the White girl, was positive about visiting Ayesha's house. African-American children and children of other groups all felt that she was happy. Children pick up on the subtleties. The White children were identifying with Olivia. She was not confident; she was a little frightened. She acted like she was not as competent. The White children wanted to see a different type of model. Many of them gave the response that she was not comfortable, because that is what they saw.

Our recommendation to the writers and the producers is that in order to get the White children to see that it is okay, you cannot present the little negative fears and anxieties. You have to show total positive feelings, an altogether positive response. This is television; this is a utopia. In addition, the finding about parents is important. After viewing a segment like this, all children—

African-American, White, Chinese-American, are giving us information about the fact that their mothers would not be happy that they have friends from other groups. We are recommending that the video show interactions between parents before and after the visit, show people in friendships that model the society that we want. We cannot put all the responsibility on the children. They are getting too many messages in the society, and they are telling us that they see that it is separate. We have to model relationships for the children in our films and in our lives.

When we think about showing the beauty, as in that song, "...the beauty that's inside," one of the things that comes to mind, and was verbalized strongly by our advisors, has to do with culture. It is important to feel strong and positive about the culture. We are linked to our past, to our ancestors, to a long and beautiful history. Some of it has rough spots, but we must begin to think about that beautiful history because we are the future for those people. When we looked at African-American culture, we thought of West Africa. We wanted to share the beauty of the drum and the dance so that African-American children could appreciate the culture. We created a segment teaching a West African welcome dance. Oscar watches and asks if they know any West African go-away dances.

After viewing this segment, the majority of the children knew exactly what was happening with the dance. Many of them could do a lot of the movements, but the children were not overly positive about this experience. Many of them did not feel that they wanted to do the African dance. The reason for that had to do with Oscar, who was playing on humor and emotion, but was also sending a negative message. The children picked up on this. Less than half of the children felt positive about the African dance. It is important to present these messages to children in a fun and exciting way without undercutting the cultural message. At times we want to give them a little more of a twist. However, the children need a very direct message, given the fact that there is so much negativity in the community.

There is a proud heritage about writing and calligraphy in the Asian-American and Chinese-American communities. We created a segment to acknowledge this. It showed a child making the Chinese character for rain. When children were shown three different Chinese characters, the majority of them were able to pick out rain after seeing the segment only one time. We received calls around the country from people who said their children were drawing rain from this segment. The majority of the Chinese children knew the character was Chinese, while the majority of the other children did not know what language it was. The African-American and Puerto Rican children did feel positively about writing in Chinese, but the White children did not feel positively about writing in Chinese.

It is interesting to hear a pattern in terms of children making statements about culture. We asked all of the children how they felt about African-American people, and only about half of them said that they feel positively. When we asked the children how they felt about Chinese people and culture, only about half of them said they feel positively about Chinese people. Four and five year olds are making statements. They are telling us things about how they see the world. They are telling us that our society is sending some strong negative messages about people who are different. It goes beyond the fact that they are different. The children are also getting messages about their culture and their traditions.

We need to demand something different from this society. We must let children know that we as adults can be loving, kind, respectful, and accepting of differences. It is our responsibility to change the future. The children are watching us. If we want to know where they are getting their messages, they are getting them from us. The children love us. They want to be like us. We have to assume responsibility for our future. America is diverse and we have to begin to hold this

Luncheon II

conversation with the children. We have to smile, and learn, and share with the children, or we will have a different future. We have to be totally positive about the changes in America, or we will have to live with the future.

A big part of why we are getting these research results at age three, four, and five is because we as adults still want to talk about those extra pounds we have not lost, that hair that is not quite as straight as we ever wanted it to be, the hair color that is not quite right. We are not satisfied. We are not happy with who we are. We resent someone else who has something. We as adults have to get comfortable with who we are so that we can help the children and change the future.

I have a message from Bert and Ernie to close with. (from video tape)

Bert: Ernie? Hey, Ernie?

Ernie: What is it, Bert?

Bert: Hey, what's the matter?

Ernie: Nothing, Bert. Nothing. It's just that...

Bert: Yeah, what?

Ernie: Oh, I don't know. I just feel terrible, Bert.

Bert: Why? Why do you feel terrible?

Ernie: Well, because...well, there's, there's nothing special about me, Bert. It's just that I'm plain, ordinary Ernie or something, I don't know, it's just...

Bert: You. Hey Ernie? Hey come on, turn around. Ernie? Look at me. That's not true. You're special. Everybody's special.

Ernie: Well, what's special about me, Bert?

Bert: Oh well, take your nose, for example. Feel your nose. Go ahead, feel your nose. Now, that is a special nose. That's an Ernie nose.

Ernie: Well, I've never seen a nose like this on anybody else, Bert.

Bert: Of course not. And how about your hair? Your hair is special. Nobody else has that kind of hair.

Ernie: Oh, really?

Bert: Yeah, that's special hair.

Ernie: Gee.

Bert: And how about your ears? Look at those ears. Those are special.

Ernie: Are these special ears, Bert?

Bert: Those are very special Ernie ears. You're a special person, Ernie.

Ernie: Hey, gee. Thank you Bert. You've made me feel a lot better.

Bert: Well, it's all true, Ernie.

Ernie: Aww. Gee whiz. Hey you, why are you looking like that?

Valeria Lovelace: He is talking to you.

Ernie: You know, you're a special person too. Sure you are. Why, feel your nose. Go ahead. Feel your nose. Hmmm? That's a very special nose you're feeling there. Mmm-hmm. Now, run your fingers through your hair. You know like that? Whooooo. Yeah, that's very special hair you've got there. And now, now take your fingers and wiggle 'em. Wiggle your fingers like that...see? See there? That's a very special finger wiggling you're doing there. So smile, you're a very special person too. Like me.

Psychosocial Adversity: Risk, Resilience, and Recovery*

Keynote Speaker: Sir Michael L. Rutter

Professor of Child Psychiatry
University of London, Institute of Psychiatry

Chair:

John Hagen
Executive Officer
Society for Research in Child Development

Discussants:

Emmy Werner
Research Professor
Department of Human and Community Development
University of California

Evelyn Moore

Executive Director
National Black Child Development Institute

Keynote Speaker: Sir Michael L. Rutter

Professor Sir Michael Rutter is Professor of Child Psychiatry at the University of London's Institute of Psychiatry. He was Head of the Department of Child and Adolescent Psychiatry until 1995. His research activities include resilience in relation to stress, developmental links between childhood and adult life, schools as social institutions, reading difficulties, psychiatric genetics, neuropsychiatry, infantile autism, and psychiatric epidemiology. His teaching is mainly postgraduate, with a regular interdisciplinary series of seminars on child development and child psychiatry. As a researcher and teacher, he is particularly interested in building bridges between knowledge of child development on the one hand and clinical child psychiatry on the other. Professor Rutter also continues in clinical practice seeing children and adolescents.

In July 1984, he was appointed Honorary Director of the newly established Medical Research Council Child Psychiatry Unit, based at the Institute of Psychiatry, London. In 1994, the Social, Genetic and Developmental Psychiatry Research Centre was established at the Institute of Psychiatry, and he was appointed Honorary Director. He has been a Trustee of the Nuffield Foundation since 1992. He is an Honorary Fellow of the British Psychological Society and the American Academy of Pediatrics, and an Honorary Member of the American Academy of Child Psychiatry, reflecting his strong interdisciplinary interests. He was elected a Fellow of the Royal Society in 1987, Foreign Associate Member of the United States Institute of Medicine in 1988, and Foreign Honorary Member of the United States National Academy of Education in 1990. In 1993, he was elected to the Executive Council of the Ciba Foundation and to the Council of the Royal Society. Honorary degrees have been awarded by the University of Leiden, 1985, Catholic University of Louvain, 1990, University of Birmingham, 1990, University of Edinburgh, 1990, University of Chicago, 1991, University of Minnesota, 1993, University of Ghent, 1994, and University of Jyväskylä, Finland, 1996. He was knighted in January, 1992.

Professor Rutter has received many prestigious awards, the most recent being the John P. Hill Award for Excellence in Theory, Development, and Research on Adolescence from the Society for Research on Adolescence, 1992, the American Psychological Association

* Originally, *Psychosocial Adversity: Risk, resilience, and recovery* (OUE201 MS=545) previously presented in South Africa (August 1995) and Ghent (November 1995).

Distinguished Scientists Award, 1995; and the Castilla del Pino Prize for Achievement in Psychiatry, Cordoba, Spain, 1995

Professor Rutter completed his basic medical education at the University of Birmingham, England, qualifying in 1955. After taking residencies in internal medicine, neurology, and pediatrics, he went to the Maudsley Hospital, London, for training in general psychiatry and then child psychiatry. He spent the 1961-62 year on a research Fellowship studying child development at the Department of Pediatrics, Albert Einstein College of Medicine, New York, returning then to work in the Medical Research Council Social Psychiatry Research Unit. During the academic year 1979-80, Professor Rutter was a Fellow at the Center for Advanced Study in the Behavioral Sciences, Stanford, CA.

Professor Rutter is the author or editor of dozens of books and has written hundreds of scholarly articles. He is on the editorial boards of some 20 journals.

Sir Michael I. Rutter: Both clinicians and social scientists tend to speak and write as if a great deal was known about how to prevent psychiatric disorders in young people. There is a vast literature on variables associated with an increased risk of disorder—ranging from broad social variables such as poverty, homelessness, and unemployment to family features such as family break-up, institutional rearing, parental neglect, and family discord to more individually focused psychosocial risks such as scapegoating and the experience of physical or sexual abuse. The task would simply seem to be that of setting about reducing the extent to which these psychosocial risk factors occur in society and impinge on young people. Of course, that is not by any means a straightforward matter (Rutter, 1982). Knowing which are the risk factors and knowing how to change them are two very different issues. Thus, what should society do to reduce the rate of family discord or parental neglect? There are some useful leads to follow, but the truth is that we do not really know.

Those are important considerations, but there are two others of at least equal importance that require our attention. First, it is crucial to differentiate between risk indicators and risk mechanisms. Risk indicators are variables statistically but indirectly associated with risk, but not reflecting the risk process itself. Risk mechanisms are variables that reflect the ways in which the risk process actually operates to bring about the disorder. Poverty and social disadvantage may be used as examples to illustrate the point. Numerous studies have shown statistical associations between both these indicators and crime. Similarly, both cross-sectional and longitudinal studies have shown that the experience of unemployment is associated with an increased likelihood that young people will engage in delinquent activities. It would seem obvious that if we could raise the overall level of income, improve living conditions, reduce the number of children being reared in poverty, and keep unemployment levels very low, this should bring about a substantial fall in crime rates. Unfortunately, the experiment has been tried and it had the reverse effect! During the period from the 1950s to the mid 1970s, living standards in most Western European countries improved greatly, the gap between the rich and the poor narrowed appreciably, and unemployment rates remained extremely low—what has sometimes been called the “golden era” that followed World War II. There were substantial measurable benefits with respect to physical health. However, contrary to expectations, crime rates soared. Moreover, other psychosocial disorders also increased in frequency among young people. Drug abuse became much more common, the rate of depressive disorders rose, and suicidal behavior increased. Why did not the expected benefits come about? The implication is that we mistook statistical association for causal mechanism and, hence, misidentified the processes by which the risks arise. Other evi-

dence suggests that the psychopathological risks associated with poverty and social disadvantage probably operate in indirect ways. In most circumstances they serve to make good parenting more difficult, and failures in parenting are more directly involved in psychiatric risk mechanisms. Of course, I do not wish to underestimate the personal suffering brought about by poverty and degrading living conditions; the relief of both is an important goal in its own right. The point is that raising the standard of living of a community will not necessarily do anything to reduce the rate of psychiatric disorder in that community. The lesson is that it is essential that our research take the crucial step of moving from statistical risk indicators to an understanding of how risk processes operate. Unless we have that knowledge, our efforts in the field of prevention are likely to be inept and ineffectual.

The second consideration is that there is huge individual variation in children's responses to stress and adversity. Even with the most dreadful experiences, it is usual to find that a substantial proportion escape serious sequelae. Over the last two decades or so there has been an increasing focus on this striking phenomenon of resilience because it has seemed to carry the hope of successful prevention. The implicit assumption has been that, if only we knew what it was that enables people to "escape" damage from seriously adverse experiences, we would have the means at our disposal to enhance everybody's resistance to stress and adversity. I want to consider this proposition critically, to examine what is known about resilience, and to discuss the practical implications that seem to follow from that knowledge.

This is not the time or place to review the many crucial methodological issues that apply to research into resilience, but I do need to note just a few of the main points that serve to shape any discussion of the phenomenon of "escape" from stress and adversity. The first derives directly from the first consideration I employed—namely the need to differentiate between risk indicators and risk mechanisms. We cannot sensibly examine escape from risk if we do not understand how the risk operates. All too often, what has seemed to be escape from risk turns out to mean no more than that the children who supposedly escaped had not really experienced a major psychiatric risk at all, or that their risk exposure had been quite slight.

The second point is that it is essential to pay careful attention to matters of measurement. Sometimes what appears to be resilience is just error in measurement. Alternatively, what seems to be escape is no more than a failure to assess an adequate range of adverse outcomes. I do not wish to labor the point unduly, but it is essential that we appreciate the many sources of misleading conclusions.

The third point is that resilience is not a single entity, and it is certainly not an absolute. No one has absolute resistance to stress, and often the "escape" from damage is relative and not complete. Good psychological function is restored but scars remain. We need to think of both susceptibility to stress and resilience as graded phenomena. Some individuals are more resilient than others, but everyone has their limits. Also, however, resilience is a term that applies to particular hazards and not to all kinds of adversities. People may be resilient with respect to one sort of risk but vulnerable to others. Furthermore, resilience does not necessarily lie in the characteristics of the individual; rather, its key features may concern the overall social context or environmental circumstances. Finally, we must get away from any notion that resilience necessarily resides in the "chemistry of the moment." Escape may come about, not because of anything that happens at the moment of experiencing the risk, but rather in the occurrence of particular preceding and succeeding circumstances. If we are to understand the phenomenon of resilience, it is necessary that we take a long-term perspective and that we do so within an appropriate developmental framework.

Plenary I

So much for the caveats; let me now turn to some of the positive evidence beginning with the lessons that emerge from what is known about people's responses to physical hazards of various kinds. We need to pay attention to research findings in the field of medicine as a whole and, indeed, in biology more generally. The first finding that is immediately striking is that resilience does not usually reside in the avoidance of risk experiences, or positive health characteristics, or generally good experiences. Thus, for example, immunity to infections, whether natural, or therapeutically induced through immunization, derives from controlled exposure to the relevant pathogen, and not through its avoidance. Resilience results from having the encounter at a time, and in a way, that the body can cope successfully with the noxious challenge to its system. In short, resistance to infection comes from the experience of coping successfully with lesser doses, or modified versions, of the pathogen. Perhaps, the same may apply in the field of psychosocial stresses and adversity.

The second feature that stands out in any review of resistance to disease is that the risk or protective influences may stem from experiences at a much earlier age. For example, it is now apparent that relative subnutrition in early infancy (as indexed by low weight at birth and during the first year of life) is associated with a much increased risk of coronary artery disease and heart attacks in middle-age. The mechanisms are not fully understood, but it seems likely that the early subnutrition may increase the organism's susceptibility to unduly rich diets in mid-life. Note that it is being underweight in infancy that predisposes you to heart disease, whereas it is being overweight in middle-age that creates the risk. The lesson is that risk factors may operate in different ways at different age periods. This is by no means an isolated finding. Not only is this particular connection over time replicated, but also there are a variety of other well documented examples of the ways in which early experiences have influences on health and illness in adult life. We may suppose that somewhat similar phenomena may well apply in the psychosocial arena.

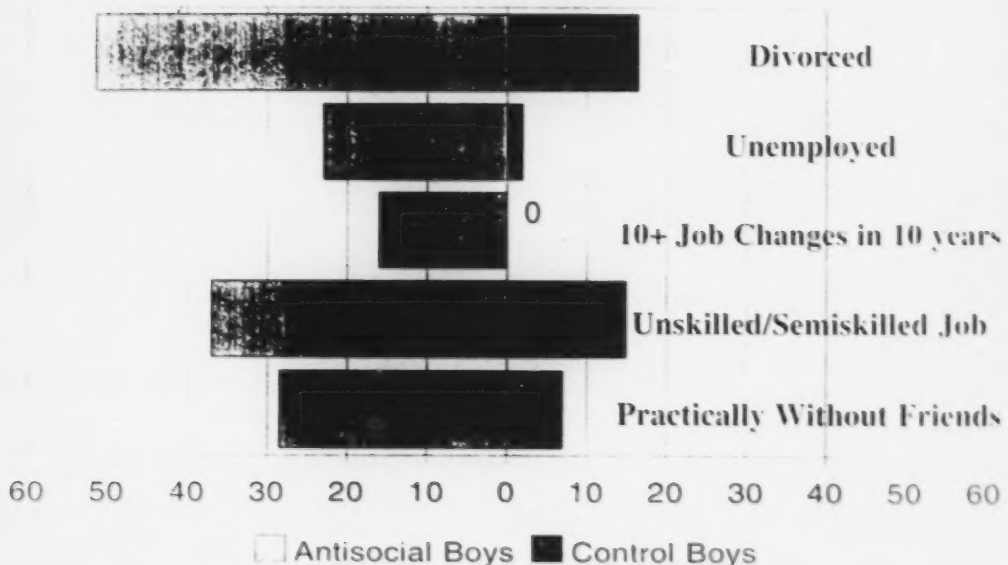
The third feature is that it is necessary to focus on risk and protective mechanisms and not on risk and protective factors. That is because the same feature may be a risk in one situation and a protective factor in another. For example, heterozygote status for sickle-cell disease is obviously a risk factor for that disease. However, interestingly, it constitutes a protective factor against malaria. In the psychological field, one might view adoption in the same way. Being adopted is clearly a protection for children born into an extremely deviant biological family, but being adopted also carries with it some psychological risks, albeit small ones. The point is simply that we must get away from thinking in terms of characteristics that are always risky or protective in their effects and, instead, focus on the specific processes that operate in particular circumstances for particular outcomes.

With those general considerations in mind, we may consider some of the specifics as they apply to resilience in the face of psychosocial risk factors. The first point to note is that evidence from behavior genetics suggests that in many, but not all, circumstances, nonshared environmental effects tend to be greater than shared ones. What that means is that on the whole, features that impinge equally on all children in the same family are rather less important than those that impinge differentially so that one child is more affected than others. In other words, it may be that it is less important that the overall family atmosphere tends to be a rather unloving or discordant one, than that one child is scapegoated and another is favored. Several practical implications flow from this observation. First, it means that, given some family-wide risk factors such as discord or parental mental disorder, protection may reside in children being able to distance themselves to some extent from what is going on. Thus, it is clear that when parents quarrel and fight, some children tend to get drawn into the dispute and may become a focus of disagreement and a

target of irritability and hostility, whereas others are able to remain protectively separate and uninvolved. Similarly, clinical observations have suggested that when a child has a parent with a serious mental illness, it may be protective for them to recognize that their parent is truly ill, and to have some of their most important emotional ties outside the family. Another implication is that it is necessary to consider individualized aspects of children's experiences. For example, Jenkins and Smith found that children were protected by a good relationship with one parent when the family as a whole was characterized by overall discord.

A rather different consideration concerns the question of where adverse life experiences come from. That may seem a curious question to ask but it needs asking because it is so obvious that stresses and adversities are not randomly distributed in the population. Some children have far more than their fair share of psychosocial hazards, whereas other children experience remarkably little serious stress and adversity. The findings on reasons for individual variations in exposure to risk environments bring out several important points. First, it is clear that people's own actions and behavior do much to shape and select environments that they later experience. For example, Lee Robins' classical follow-up study of boys with conduct disorder showed that, as compared with a general population control group, they had much higher rates in adult life of unemployment, disrupted friendships, broken marriages, lack of social support, and poor living conditions (See Chart 1). Of course, in a real sense, these adversities in adult life represented a continuation of their psychosocial problems, but it is equally true that by their behavior, they

CHART 1
**Childhood Behavior and Adult
Psychosocial Stressors/Adversities**
(Data from Robins, 1966)



BEST COPY AVAILABLE

Plenary I

were creating for themselves a range of risk experiences that are known to predispose to depression and various other psychopathological outcomes. It is important to emphasize that just because people bring about their own experiences does not mean that they are unaffected by them. Thus, people choose whether or not they smoke cigarettes, but the fact that they have chosen to expose themselves to carcinogens, nicotine, and carbon monoxide in no way negates the fact that smoking creates a serious risk for lung cancer, coronary artery disease, and various other conditions in adult life.

The importance of this observation in relation to the phenomenon of resilience is the implication that people can do a good deal to influence what happens to them. In that connection, it is relevant that our own research and that of John Clausen have shown the protective effects that stem from young people actively "planning" how they deal with what happens to them in important domains of life such as marriage or work careers. In our follow-up study of institution-reared children, many of their later problems stemmed from the fact that they felt at the mercy of fate and did not take active steps to deal with the life challenges as they presented themselves. It appears that resilience may be fostered by steps that make it more likely that people will feel in control of their lives and become effective in shaping what happens to them.

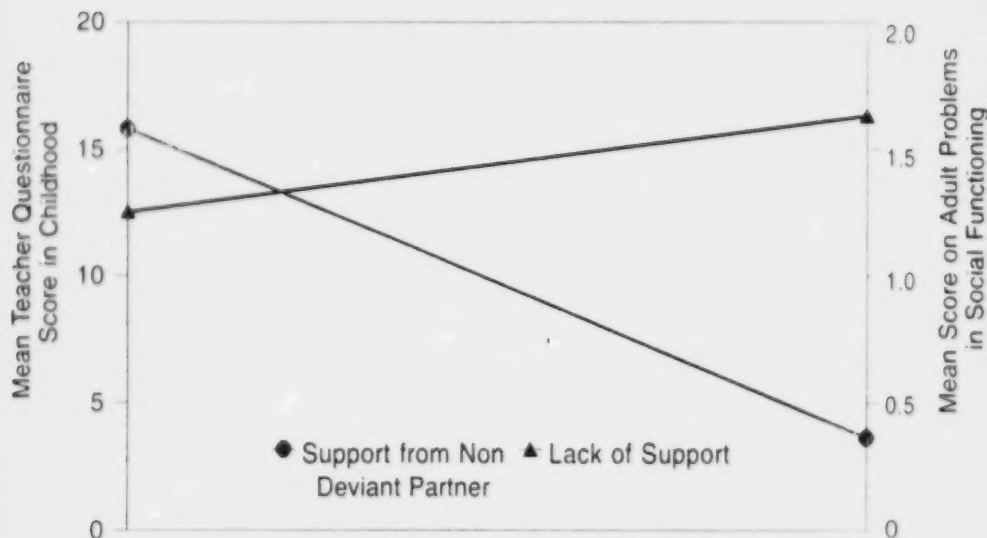
Of course, the answer to the question of where adverse life events come from is by no means restricted to individual considerations. It is clear that, to an important extent, part of the answer lies in societal factors. For example, the fact that in the United Kingdom, as in many other countries, the unemployment rate in young people is much higher among African-American youths than among White youths is largely explicable in terms of racial discrimination. The disparity in life circumstances between African Americans and Whites in the United States is at least as great as that between African Americans and Whites in the U.K. Moreover, socioeconomic differences between ethnic groups are paralleled by comparable contrasts with respect to outcomes as diverse as infantile mortality, teenage pregnancy, risk of death by homicide, and crime. Multiple causal influences are involved, and the problem does not have a single straightforward solution. Nevertheless, there are three crucial points. First, societal influences have a major impact on people's life experiences; the likelihood of encountering serious psychosocial hazards varies enormously by both ethnicity and geography. Second, these disparities in life experiences have major health implications. Third, political decisions impact greatly on these patterns. Thus, both the U.K. and U.S. stand out among industrialized nations in the extent to which the divisions within society have increased during the last two decades. The rich have gotten richer, but the poor have been left behind with their situation worsening in key respects. These widening inequities have been shown to have adverse health consequences. The precise mechanisms remain ill-understood, and the causal processes are likely to involve indirect chain effects. Nevertheless, although population-wide influences do not determine individual differences to any marked extent, they do play a significant role in determining the overall level of good and bad experiences of various kinds, and these matter with respect to health outcomes.

I noted earlier that resilience could reside in both preceding and succeeding circumstances. In that connection, it is necessary to recognize the importance of potential turning points in people's lives whereby those who seemed set on a maladaptive life trajectory are enabled to turn onto a more adaptive path. For example, Glen Elder's analysis of the California longitudinal study data indicated that for young men from a disadvantaged background, early entry into the Armed Forces proved to be a protective factor in relation to adult outcomes. That seemed to be because entering the Army enabled them to continue their education and also allowed them to postpone marriage to a time when they were both more mature and also were in contact with a wider social

group than that prevailing in their earlier disadvantaged circumstances. Of course, it is not that being in the Army was in and of itself an experience that led to resilience. Indeed, people from a nondisadvantaged background who entered the Army at a later age tended to find the experience a very disruptive one because it interrupted their careers and interfered with their family life. Rather, it is that, in certain circumstances, Army experiences brought with them other benefits that helped to create greater resilience. Once more, the point is that we need to think in terms of person-specific circumstances and not just in terms of something that brings about general good.

It should be noted that, as with the Army example, many of the important turning points that bring with them enhanced resilience occur in adult life. For example, our own research has shown the important protective influence associated with a harmonious marriage to a nondeviant spouse (See Chart 2). It may be felt that that is not a very helpful finding in that we can scarcely write out prescriptions for good marriages for people. However, a developmental perspective shows that there are, in fact, important policy and practice implications. That is because it is not accidental whether people make a harmonious marriage to a nondeviant person; to an important extent, it is predictable in terms of their prior behavior and experiences. We found that, on the whole, people who exerted planning in their lives were more likely to make a successful marriage. It was necessary, then, to go back one stage further and ask what it was that made it more likely that people would show a planning tendency. Our results showed that, for children from a disadvantaged background, positive experiences at school made planning more likely. The mech-

CHART 2
Turning Point Effect of Partner in Females
with Antisocial Behavior in Childhood
(Pickles, 1996)



Plenary I

anisms remain ill understood, but probably what is happening is that success in one arena gives people positive feelings of self-esteem and self-efficacy that make it more likely that they will have the confidence to take active steps to deal with life challenges in other domains of their lives. It should be noted, incidentally, that the positive experiences at school, at least for this group, did not mainly concern academic success. The positive experiences were quite varied and extended from success in sport, or music, or arts and crafts to positions of social responsibility within the school. The implication is that the experience of pleasurable success is probably helpful in enhancing those aspects of the self-concept that promote resilience.

The third key concept to mention is that of individual variations in susceptibility or vulnerability to adverse experiences that stem from sensitizing or "steeling" experiences at an earlier point in people's lives. It is clear that stress experiences may work in either direction, but there is a paucity of evidence to tell us which consequence is to be anticipated in each circumstance. However, animal evidence indicates that acute physical stressors lead to lasting neuroendocrine changes that are associated with increased resistance to later stress. One study of children's admission to hospital showed that those who had experienced previous happy separations, staying with friends or grandparents, were less likely to be upset by admission. By analogy with the example of infections given earlier, we may suppose that "steeling" effects are more likely to arise when people have coped successfully with stress experiences. For example, to turn again to the Elder California studies of young people growing up during the Great Depression, older children who had to take on increased responsibilities, and did so successfully, tended to fare better as a result, whereas younger children who were less able to cope with all that was involved tended to suffer.

It is important also to recognize that individual differences in susceptibility to adverse experiences may derive from personal characteristics that have an important constitutional component. For example, the temperamental characteristic of behavioral inhibition studied by Kagan et al. in human infants and by Higley and Suomi (1989) in monkeys represents a feature of this kind. It is certainly important that we recognize the reality of these intrinsic individual differences, but equally important that we appreciate the ways in which they seem to work. Two key features may be mentioned. The first is that, although behavioral inhibition clearly has an important genetic component, environmental influences are also important. How children are dealt with makes a difference to their temperamental characteristics. The second point is that these temperamental features do not lead inevitably to any form of disorder. Rather, they influence how people respond in particular stress or challenge circumstances. In other words, what is important is the interplay between people and their environments. That interplay is potentially open to influence in either a beneficial or a harmful direction. It is up to us to undertake the type of research needed in order to find out how to influence interactions in the appropriate direction.

The fifth point concerns the importance of how people appraise their circumstances. Research into life events has made it clear that contextual factors are most important. The same event is likely to be viewed quite differentially by different people. For example, for some people, promotion at work is seen as an awful burden, bringing with it terrible worries as to whether the person can cope with the increased responsibilities. For other individuals, by sharp contrast, promotion is seen as a welcome challenge and a public recognition of their own positive personal qualities. It is clear that cognitive factors play an important role in emotional disturbances and also in how people deal with social problems of various kinds. A recognition that this is so has led to the development of various forms of cognitive behavioral therapy and of interventions designed to enhance successful social problem solving. It is too early to know how these methods

compare with more traditional therapies but, in the right circumstances, they do seem effective, and also carry the potential benefit of providing skills and attitudes of mind that may be helpful in dealing with later stresses and challenges. Almost certainly, it is not that there is one "right" way of thinking about things, or one optimal style of coping. Rather, what seems important is to approach life's challenges with a positive frame of mind, a confidence that one can deal with the situation, and a repertoire of approaches that are well adapted to one's own personal style of doing things.

In dealing with people's appraisal of challenging situations and of their style of coping with stress experiences, the emphasis has been on both the cognitive processes and the social problem-solving strategies employed at the time of the risk experience. However, in addition, it may also be important to know how people think about their negative experiences after they have occurred. Mary Main's Adult Attachment Interview is based on the notion that it matters how people think about bad relationships that they had with their parents when young. It is argued that, for psychologically healthy adult development and adult relationships, it is important that people appreciate the importance of interpersonal relationships, that they accept the reality of the bad experiences that they encountered, and that they find a way of incorporating the reality of their bad experiences into their concept of themselves and of their lives, building on the positive but not denying the negative. The data as yet are far too sparse to regard these ideas as having been put to rigorous test. What is clear, however, is that people do vary enormously in how they think about trauma in their past. There is some suggestion that adult functioning is more likely to be impaired when the memories are distorted, dealt with defensively, and incorporated into their own personal schemata in a disorganized fashion with either distortion and denial or enmeshed preoccupation.

The last consideration concerns the influence of protective mechanisms. They refer to catalytic or reverse-catalytic effects by which a feature modifies the influence of some risk factor. Up until recently, the main focus in discussions on psychosocial risk has been on the reduction of adverse influences. Of course, that is an important goal, but it is equally important to pay attention to those features that, while not directly promoting good outcomes, enhance resistance to psychosocial adversities and hazards of various kinds. Surprisingly little is known about protective mechanisms, but some of the examples already given under other headings, for example, the phenomenon of planning, probably work in this manner. Because there has been so little study up to now of protective influences, no firm conclusions are warranted. Nevertheless, a review of what is known suggests that the protective processes probably include five main sets of mechanisms.

First, there are those that reduce the risk impact by virtue of effects on the riskiness itself or through alteration of exposure to, or involvement in, the risk. For example, the work of Gerald Patterson and his colleagues, as well as other investigators, has shown the importance of parental supervision and monitoring of their children's activities in order to protect them from getting into delinquent groups and delinquent activities. Our own work, too, has shown that children from high-risk backgrounds who are able to join and form part of a positive peer group are less likely to have adverse outcomes in adult life. Several studies of parental conflict and parental divorce have indicated that the risks to the children are quite strongly related to the extent to which children are drawn into parental conflict either before or after the break-up of the marriage. Our own research, too, with the families of mentally ill parents showed that children who were the targets of hostility or who were scapegoated during family conflict were more likely to suffer and that, conversely, those who managed to avoid getting caught up in family fighting and disputes fared much better. Similarly, as I noted earlier, there is limited evidence that when children have a seri-

Plenary I

ously deviant, disturbed, or mentally ill parent, it may be helpful for them to recognize that the parent is ill in some way and to distance themselves from the parent exhibiting abnormal behavior.

A second protective mechanism resides in the reduction of negative chain reactions. These mechanisms apply both at the time and in terms of the way sequelae are dealt with. For example, Patterson's studies of family conflict showed the high frequency with which conflict in the families of antisocial boys tended to escalate with someone's hostile remark leading to an angry response, which, in turn, lead to further hostile interchanges that often served to bring other members of the family into the dispute. Effective means of cutting short these coercive cycles through good humor, diversionary tactics, or some other means may be quite protective. Similarly, intervention research has shown that, given the right approach and circumstances, children can be helped to learn appropriate social problem-solving strategies so that they can cope better with frustration, disputes with friends, and competition for desired toys or activities.

In the longer term, how girls and their families respond to a teenage pregnancy may make a big difference to the outcome. For some people, if the pregnancy is unwanted and if it has not arisen in the context of a stable relationship, a termination may be the best option. For others, family support both through the pregnancy and after the child has been born may be the better option. At one time, girls who became pregnant more or less automatically were expected to leave school, but, fortunately, that is no longer the case. It is important that the difficulties of rearing a child, when still not quite an adult yourself, should not be compounded by the disadvantages of dropping out of education prematurely. In the same sort of way, it is important that young people's coping mechanisms do not involve steps that themselves bring risk effects. Thus, coping with stress by reliance on drugs or alcohol brings its own set of problems that are likely to make things worse, rather than better.

A third protective mechanism lies in the promotion of self-esteem and self-efficacy. I link these two slightly different aspects of self concept because it seems that it is important both that people feel good about themselves and that they have a positive sense that they can cope with the challenges and psychological tasks that they encounter. In other words, it is not just having the appropriate repertoire of social problem-solving strategies that is important, but also the attitude of mind, the cognitive set, or the self concept that enables the person to tackle what is required with a confidence that they will succeed in what they have to do. This positive self concept seems to come about through three somewhat different routes. First, the experience of secure, supportive, and warm reciprocal relationships seems important. This is usually portrayed in attachment terms because, at least in childhood, the attachment aspects of the child's relationships with parents seem particularly important. However, there are probably fairly direct parallels later in terms of close friendships and love relationships. Second, it seems that the successful taking on of responsibilities and successful task accomplishment also serve to give people the necessary sense of confidence and high self-esteem. Having succeeded in one set of tasks, people appear to tackle other, somewhat different tasks with greater confidence. Third, there is the somewhat related phenomenon of successful coping with manageable stresses. It is not sensible or desirable to seek to protect children from all stresses. Challenges and difficulties are a necessary part of growing up and children need to learn how to cope successfully with them. Of course, it is important that the level of difficulty, the timing, and the pacing of the challenges and stressors be ones that are of a kind that make it likely that the child will be able to succeed.

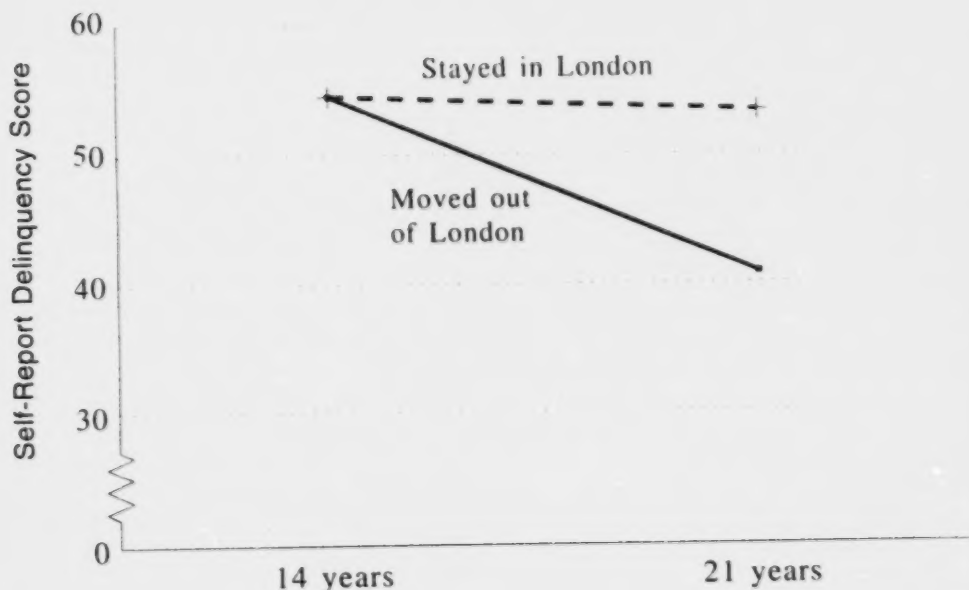
The fourth type of protective mechanism concerns the opening up of positive opportunities. This is most obviously seen, of course, in terms of educational and career opportunities that serve

to take young people away from their stressful, depriving, or disadvantaging environment. However, the same applies to marriage. The much increased risk of marital breakdown associated with teenage marriage is well demonstrated. It is likely that there are several different reasons why this risk arises. In part, it may be because teenagers have a narrower choice for potential marriage partners, and for those from a high-risk background, many of the potential partners are likely to be similarly disadvantaged and often exhibiting deviant behavior.

Another means by which positive opportunities may be opened up is through a geographical move. For example, Osborn, in a prospective longitudinal study of working-class boys in inner-London, showed a substantial reduction in delinquency among those who moved away from the metropolis, a drop not explicable in terms of their prior behavioral characteristics (See Chart 3). The data do not show exactly how this benefit arose. It may have been through a change in peer group, an impact on family functioning, a reduction in opportunities for crime outside inner-London, or an alteration in the nature of school influences. However, the point is that a major geographical move, if it is of the right kind, may serve to create new opportunities of a beneficial kind.

The last type of possible protective mechanism is of a somewhat different kind and one for which there is only limited supporting evidence at the moment, although it may turn out to be quite important. This concerns the cognitive processing and mental representation of negative experiences in childhood. Thus, as I have mentioned, Mary Main and her colleagues have devel-

CHART 3
Moving Away from London
and Fall in Delinquency
(Data from Osborn, 1980)



oped this notion in relation to childhood attachment experiences. The focus here is not so much on what the experiences were actually like in childhood, but rather on the way they are thought about in adult life. It is argued that it is protective for people to accept the reality of their negative experiences, rather than to deny or distort what happened, but to be able to focus on positive aspects and to incorporate the whole into their own personal schema. Empirical findings show that there is a meaningful distinction between objective experiences and the way they are conceptualized later, as well as some evidence of the validity of the later.

As is all too evident from this brief overview, while we have an understanding of some important protective mechanisms, we do not as yet have any ready answers to the key question of how to bring them about. Nevertheless, it would be a mistake to underestimate the extent to which research findings have led to a much better appreciation of how risk and protective mechanisms operate. The crucial need is to differentiate between risk indicators, meaning factors statistically associated with risk but not themselves reflecting the risk process, and risk mechanisms, meaning the ways in which the risk operates in bringing about an increased liability to disorder. It has become apparent that people vary greatly in how they respond to stress and adversity. In part, this individual variation derives from personal characteristics, in part from previous experiences, in part from the ways in which the individual copes with the negative experience, in part through indirect chain effects stemming from the experience and how it is dealt with, and in part by subsequent experiences. In each case, the focus needs to be on the interplay between people and their experiences, and part of that interplay is their cognitive processing, or ways of thinking about their experiences and their concept of themselves as individuals. I have sought to outline some ways in which resilience may be promoted. The efficacy of such possible ways of intervening remains largely untested and, while the ideas are not yet at a stage at which they can be translated into a specific program, they do provide important useful pointers towards the various means by which the issues might be tackled.

Emmy Werner: I would like to relate some similar experiences from our own study and try to tie it in with some of the interests that you as an audience have. I do not want to reiterate the findings of our longitudinal study, but I can assure you that Michael's findings from his studies and the people he cited come very close to what we were able to see over time from birth through infancy, early childhood, middle childhood, adolescence, the early thirties, and now forty.

What I would like you to keep in mind, in reference to what Michael has said, is the importance of the individual differences that we see in all of the prospective studies of children's reactions to both positive and negative influences in their lives. It is important to keep that in mind if you are using the knowledge base and conceptual base that Michael provided for the evaluation of intervention programs. You may recall that the five important mechanisms that he just discussed were reduction of risk factors, reduction of negative chain reactions, promoting of self-efficacy and self-esteem, opening of positive opportunities, and cognitive processing and mental representation of what the painful experience may have been. I suggest that not all of these may be tested with very young children, but some can. Head Start, especially high-quality programs, can and does foster many of these protective mechanisms for both children and parents. For documenting that, however, we need longitudinal evaluation of the process of interventions, not just of programs. Let me suggest a few ways of looking at these mechanisms that are based on some of our own findings. What we try to do is link the protective buffers in children's lives to the sources of support they had along the way. In Head Start one needs to look at the constant reconstruction of the environment within the personal context of the child. Head Start, or some other

good early intervention program, has the opportunity to study three major phenomena that would fit into Michael's five risk mechanisms. One is the synergistic or multiplier effects of the different Head Start components on the lives of the participating children and families. Two is the way different children from the same families who were served by Head Start at different times responded to the intervention and sources of support, and the impact of different caregivers and teachers who tried to develop and help foster the child's self-efficacy and self-esteem.

Let me briefly illustrate the multiplier effects. We know from studies of children who live in developing countries that nutrition, health care, and parent education together usually create "better outcomes" than either one of these interventions alone. We know, for instance, that they increase the activity level and the social responsiveness of young children. We know from our study and others that over time, active and social responses from toddlers elicit more positive responses from parents and other caregivers, and such youngsters in middle childhood tend to attract a wider network of caring adults. Here you have a possibility over a period of years to demonstrate that that effect truly exists. We also know that low-income parents who are better educated generally make better use of available health care and social services. They also tend to interact more positively with their young children. This positive interaction is associated with greater autonomy and social maturity of the children in the preschool years. You begin to see how some of these multiplier effects and the interaction between what the child gains and what the parents do can greatly enhance the various mechanisms that Michael spoke about. Scholastic competence leads to higher self-esteem in middle childhood and adolescence. This ongoing chain effect could be demonstrated in smaller segments with a variety of follow-up studies.

I also want to stress the importance of looking at shared versus nonshared family environment because it would seem that the Head Start population of children would provide great opportunities to study this. In our small sample of children, 700 or so, about one third did attend Head Start, and we have families where three, four, or five children attended Head Start. It would be important to see how these children, differing by birth orders, gender, and temperament, among others, utilized this experience. It would be interesting to see if there are spillover effects. We know from other studies by UNESCO, UNICEF, and WIC that older children tend to help other children and teach them certain helpful health and nutritional habits. What do we know about this in Head Start?

In addition, many parents that are served by Head Start are single mothers. We know that single mothers can be helped by other competent adults. One of the issues that arises is what roles grandmothers play in helping establish these protective mechanisms, together with the mothers and caregivers in Head Start. We have some data on this from the foster parent program that deals mostly with handicapped, developmentally disabled children. It would be interesting to utilize some of these data on the role of grandparents.

Last is the cognitive appraisal of the meaning of adversity. We find that those children who were poor and lived in many different dysfunctional circumstances and who still had troubles in midlife were people whose anger scores increased significantly from adolescence through young adulthood into midlife (age 40), whereas the ones who seemed to master adversity, at least with developmental tasks we have studied, had anger scores that went down during that same time period. Quite early they learn to convert the bitterness and anger about having been abused, misunderstood, persecuted, or being poor into compassion. I do not know the answer to how this phenomenon occurs, but I would hope that one of the skills taught in preschool would be not only to deflect anger, but also to translate it into something positive.

Evelyn Moore: There is an old saying, "I'm in the right church, but the wrong pew." I had difficulty right off with the title of this presentation. The first title that was sent to me was "Strengths Arising from Adversity: the Challenge to Programming for Young Children." Then the title this morning in the program is "Psychosocial Adversity: Risk, Resilience, and Recovery." The reason I had some difficulty was this insistence that we are going to talk about strength, but we put it into a deficit orientation. When you say adversity, you have conflicting notions. If you are strong, it is assumed that you can overcome adversities. This morning I ticked off a lot of the language that was used as we talk about resilience and strengths: disadvantaged, dysfunction, deviant, deprived, risk indicators, risk mechanisms, interventions. I said to myself, I am happy my mother did not know that we had all of these risk factors whirling around us as we grew up. I grew up in a family of eight children. My mother began as a teenager. That is a risk factor. She had less than a high school education, another risk factor. My father had a fourth-grade education, another risk factor. We certainly endured a number of hardships that were mentioned this morning.

We have to disconnect ourselves from our tendency to say that families do not know anything as they struggle with the day-to-day problems of raising their children and making a living. In my family, for example, towing the line was something we were made to do, and that could be considered another kind of "halfway" risk factor. We were made to believe that if you worked hard, you could do better, and you had better work hard. The point I want to make is that we should overlay our strength and resiliency movement with a positive expectation approach rather than the deficit orientation we seem to cling to. I especially connected with Michael when he said that individual variations make a lot of difference. It is the way we think about these negatives that often influence the outcomes.

There are thousands of uncaptured stories in the Head Start community that convey the same kinds of strengths I shared with you in my own family. There is a need to measure those experiences in some way as success indicators. What better program to do this than in Head Start, which is child centered, family focused, and community based. Even though our rhetoric speaks to strengths, we continue to gear our research and our thinking toward the deficiencies of the child, the parents, and sometimes the community.

Kristin Moore from Child Trends captured it when she wrote, "Our capacity to describe the problems exceeds our capacity to understand the factors that explain normal and successful development." If we are going to change this, it is going to require nothing less than a transformation on the part of each of us. We talk about our own people as if they are not connected to us. That is, if you are in poverty, it is all over for you. I was pleased to hear Michael speak to that issue, that poverty does not necessarily make for the outcome and the condition. We have almost institutionalized the fact that there are certain groups of children in our country that are not going to make it. We have almost declared that if you are in poverty, it is going to be very hard to make it. We cannot throw up our hands.

A second point Michael made that I can identify with is the racial divide and class bias we have. The reason why we must have a transformation is that we have used risk factors as our security blankets, social indicators that allow us to continue to blame the problem on the victim. Either your mother's education is too low, or your mother has too many children. You live in public housing, your mother lacks social support; therefore, you just cannot make it. Now we are holding children back in kindergarten. I visited a school system where they had something called, "transitional kindergarten." How can you flunk kindergarten? This is what is happening in our country. Falling back on these risk factors allows us to do that. The more research that we have

that highlights these deficiencies, the more ammunition policymakers can use to demonize poor families. Moving our children ahead and making our children a priority is the number one challenge in America.

In closing, there are three things I want to recommend. First, focus on strengths. In 1971 Robert Hill wrote *Strengths of Black Families*, based on his research. He identified some of the same factors that were identified for us this morning: strong kinship bonds; strong work orientation, which debunks welfare stereotyping; a strong religious orientation that is vital and alive in our community today; and a strong achievement orientation. Unfortunately, to my knowledge, this has not led researchers to explore in any systemic way the functioning of families that have not failed, that somehow manage to sustain themselves and experience success with their children in spite of the challenges. Why is it that these families are not used as a source from which to draw data and conduct research?

Second is the diversity of our families. Head Start, my hat goes off to you. I am personally proud to have been part of the technical resource team working on the national readiness goals, which affirmed young children's strength, especially as it relates to temperament, approaches to learning, and language and culture. In *Reconsidering Children's Early Development and Learning* (a report from the National Goals Panel), a case is made for learning more about the interplay between context and culture, and children's ability to appear cognitively competent. Recognition is given to different kinds of intellectual abilities. Combined with culture, it determines knowledge that is valued and transmitted in the children's own communities. The report also points out that children's abilities and understandings are frequently highly context-dependent. In other words, in situations that are familiar to a child, and where he/she can properly interpret the requirements of the situation, the child seems competent. Where the situations are unfamiliar, the ground shifts. Children may respond in ways that adults determine to be developmentally delayed. I will never forget how in the original Perry Preschool program we were using a standardized test. One of the items was, "Where do you keep a toothbrush?" It was a classification question; for example, the sofa belongs in the living room, the dishes belong in the kitchen, and so forth. One of my best and brightest students said, "In the refrigerator." The child held his ground. Some of you sitting here know why the child gave this answer. It is the only way to keep roaches from crawling over the toothbrush. That is an example of context. That child failed the item. Therefore, the question becomes how do we translate these skills into positive school behavior, or how do we change the schools to take this context into account. My recommendation takes me back to Head Start and the intimate involvement of parents. Head Start shows us that a partnership with parents can help build bridges and insure that family strengths get translated.

My final point that can help promote the agenda for strengths and resiliency is advocacy. All young children in America deserve to be in a program like Head Start. It will only be then that we will be strong, and when we say we want to deal with strengths, they will listen.

John Hagen: The one thing that I did not hear anyone specifically address has to do with critical periods or stages. While we all agree that there is a good deal of evidence that there are certain times that are especially critical for certain kinds of input or learning for children, it is never too late to talk about, plan, and use interventions. That point was implicitly made, but perhaps was not explicitly stated: there may be interventions that are especially appropriate for teenagers, others even well into adult life.

Plenary I

Audience Questions and Comments

Comment: I would like to cite a case study that addresses the inoculation theory of resilience to which Sir Michael referred. We made a presentation on resilience at a research conference in 1990, and as a result of that, a newspaper writer picked up the term "transcender," which we did not use, but someone else had. That got into the syndicated columns and went across North America. We got a lot of letters from across the country from people who identified themselves personally as transcendents. We conducted a study with them, and one of them turned out to be a successful writer in Berkeley who had an interesting story to tell about her own childhood: she had been exposed to a dysfunctional family, mainly a father who was both manic-depressive and alcoholic and who was abusive to his children. A couple of years ago, I was in Berkeley and had lunch with her. She described a technique that she developed as a child for dealing with her problems with her abusive father. When he would come home drunk, she knew that she was headed for trouble because she was the primary target for his aggressive impulses. She developed a tactic of meeting him at the door and giving him a big hug. She did this so that she could get a whiff of his breath. If he had been drinking heavily, she would disappear for the evening because she knew that she was going to be the principal recipient of his aggressiveness. Also, in her response to us, she suggested that we talk with her younger sister, who was also a successful person, a psychological counselor in Oregon. There was a third daughter who was younger and who was clearly identified by both of them independently as being passive and not a target of the father's aggression. Both of them identified the youngest daughter as the one who was the most damaged psychologically as an adult. This reminded me of a concept introduced a quarter of a century ago by James Anthony, who used the term "invulnerable children of psychotic parents." These children are born with a temperament that is very sunny, wholesome, contagious, and charismatic. Anthony made another observation that the child who is born of a schizophrenic parent has a much easier task than the one who is born to a manic-depressive parent, because that child cannot develop a consistent pattern of coping with the pathology of that parent.

We often think that resilient people are wholesome and unscarred. Our impression in talking with these resilient people that identified themselves as transcendents is that they are very scarred, but they have learned to successfully cope with the kinds of adversity that they lived with in childhood and adolescence.

Michael Rutter: The original concept of invulnerability was seriously misleading in that respect. The ways in which you describe these individuals taking active steps is very much in line with what we now know about resilience. It also indicates that people have their own ways of doing it. There is not *a* way. Certainly it is quite wrong to think of people being unscarred. That is not the way it works with physical hazards; it is not the way it works with psychosocial hazards. However, that does not mean that the scarring need necessarily interfere with functioning. You can be scarred and still function very well. It is that mixture on which we need to focus.

The Reality of Partnerships

Chair:

Sarah Greene
Chief Executive Officer
National Head Start Association

Introduction:

Willie James Epps
Director, Southern Illinois University at Edwardsville
East St. Louis Center

Presenters:

Hiram Fitzgerald
Coordinator, Applied Developmental Science
Michigan State University
Professor of Psychology
"Applied Developmental Science and University/Community Partnership"

Stephen Williams
Physician, Mott Children's Health Center
Vice President for Community Relations
Adjunct Clinical Professor of Pediatrics and Human Development
Michigan State University
"Evaluating and Developing Urban Community-Based Interventions"

Mark H. Schauer
Prevention Coordinator
Calhoun County Human Services Coordinating Council
"Evaluating System Changes in Community Human Services Programs"

L. Annette Abrams
Vice President for University Outreach Office
Kellogg Center, Michigan State University
"Policy Issues"

Mary Fulbright
Director of Community Services Development Center
University of Texas at Arlington
"University of Texas at Arlington Margaret Cone Center Longitudinal Study"

L. Mike Rice, Jr.
President, Texas Instruments Foundation
"The Foundation Perspective on Young Child's Academic Competence"

Wanda Smith
Executive Director
Head Start of Greater Dallas
"Partnership Implications for Head Start Agencies"

Discussants:

Ron Herndon
President, National Head Start Association
Executive Director, Albina Head Start, Portland, Oregon

Lonnie Sherrod
Executive Vice President
William T. Grant Foundation

Plenary II

Sarah Greene: This Plenary Session, entitled "The Reality of Partnerships," sets the tone of our theme, "Making a Difference for Children, Families, and Communities: Partnerships among Researchers, Practitioners, and Policymakers." We are going to hear examples of partnerships that are working for the betterment of children and families.

Willie James Epps: The first group represents a two-way interdisciplinary partnership between a university and a community. It is the "Applied Developmental Science and University/Community Partnership."

Hiram Fitzgerald: In an essay published in 1994, Ernest Boyer called attention to a wide array of societal problems that threatened the stability and viability of American society. We know this list well: child poverty, infant mortality, homelessness, substandard housing, the school crisis, youth crime and violence, adolescent pregnancy, lack of immunization, and substance abuse. Boyer challenged academia to find solutions to these and other pervasive societal problems. He argued that it is time for institutions of higher education to put into practice the commitments to service embedded in their mission statements. Boyer's call was especially directed at social and behavioral scientists, and he challenged members from these disciplines to engage the community in order to find solutions to even the most trenchant problems. Applied Developmental Science is rapidly becoming academia's response to Boyer's challenge.

According to Celia Fischer, Richard Lerner, and their colleagues, Applied Developmental Science represents "the programmatic synthesis of research and applications to describe, explain, and provide preventive and enhancing uses of knowledge about human development." It is applied because it has direct implications for what individuals, practitioners, and policymakers do. It is developmental because it focuses on systematic and successive changes within human systems that occur across the lifespan. It is science because it is grounded in a range of research methods designed to collect reliable and objective information that can be used to test the validity of theory in applications.

At Michigan State University, Applied Developmental Science (ADS) is conceptualized as a unifying theoretical and methodological framework for faculty and staff in the university's diverse departments, schools, institutes, and centers. It is an interdisciplinary approach to the development of problem-centered university/community partnerships, and the development of delivery systems for building the evaluation capacity of local human service agencies that serve children, youth, and families. As an organization, ADS is a catalyst for linking faculty and institutional resources to specific community programs. It is a method for building interdisciplinary teams that focus on community problems with minimal interference from disciplinary turf issues, and it provides a model for pulling together resources to develop innovative ways to attack social problems.

Members of the partnership at all levels develop a mission statement that drives their work and outlines one or more major partnership activities. This statement must include two essential components: long-term commitment to program development; and development of a plan for sustainability. The partnerships that we have formed have generated a set of guidelines or standards of practice that we believe optimize chances for university/community partnership success:

1. *Shared outcome-oriented work plan* Team members working on each identified activity develop a concrete plan for achieving objectives from their mission statement. This plan clarifies how the team interprets the mission that guides their ongoing activities.

2. *Shared program policy rounds.* At least semiannually, a diverse audience meets to discuss lessons learned from the partnership's activities and to consider work plan and program modifications, policy agendas, future directions for collaboration, and the potential linkages involved in similar activities.

3. *Shared resource development.* All members are expected to contribute equally—including in-kind provisions, travel, and expenses—and to work together to seek both short-term and long-term funding.

4. *Shared scholarship.* Throughout all phases of the partnership, shared scholarship is essential. All team members understand and participate in research that is undertaken and are involved in presentations and publications related to it. Similarly, everything learned within the partnership must be distributed and/or presented so that it informs the desired audience of each team member. This requires developing tangible products ranging from journal articles and books to briefs, brochures, and posters.

5. *Cross-site linkages.* In an effort to generate new knowledge and develop innovative responses to community concerns, all partners must be open to interactions with other sites, partners, and activities when they are relevant to both parties.

6. *An administrative management team.* An administrative management team is created for each partnership in order to facilitate and guide the ongoing partnership activities and goals. This team tracks the progress of various activities, schedules program policy rounds, and meets periodically to review program activities.

In this plenary session we feature two of our community partnerships: one with a broad-based collaborative body responsible for integrated oversight of county-wide human services; and the other with a private community-based health center delivering a wide range of preventive intervention programs and health services. We conclude with a brief discussion of public policy issues generated by these partnerships.

Stephen Williams: I will provide the community perspective of this partnership. Flint and Genesee Counties share the birthplace of General Motors (GM) and the Union of Automobile Workers (UAW), an illustrious past, and once enjoyed nearly the highest per capita income in the United States. As GM, the area's principal employer, has downsized over the past two decades, Flint has become more synonymous with "Roger and Me." Flint does get more than its share of bad press; however, 45% of the children in Flint live in poverty, ranking as fourth worst in the country among major cities. In addition, infant mortality, teen pregnancy, and youth homicide rates are far too high. The job prospects for graduating seniors are unpromising, given that their achievement scores rank at the ninth percentile on average. Their futures are uncertain. A flip of the coin might be a generous estimate of the prospects for improvement. Technology and corporate downsizing threaten the economic life-blood of all communities. Over the next decade the future is particularly problematic in Genesee County because of the continued excessive dependence upon a single industry. Does this tell the whole story? Not by any means. Genesee County is blessed with substantial resources and some innovative county-wide, community-wide coalitions. These coalitions have promised an awareness of a need to change, a real desire to do it, and the outline of a process by which it can be accomplished. Counted among the resources is this relatively new partnership between MSU and the Mott Children's Health Center.

Plenary II

Today we are confronting discouraging outcomes in most urban communities. Inadequate parenting, unnecessary school failure, premature pregnancy, drug abuse, and violence and despair have a common source in the disconnection of individuals across the gulfs of race, age, gender, income, culture, and geography. City centers are isolated from suburbs, deserving and needy families are separated from essential resources, and adolescents and seniors are equally divorced from expectations of useful contributions to their communities.

The remedy lies in bridging gaps and building reciprocal caring relationships, and this requires a concerted effort. We know from our own observations and the lessons of academic research that health, resilience, and well-being absolutely depend upon connections and reconnections, and that they must be both real and enduring. These reconnections, and those nurturing relationships that they enable, require communities to define a common vision, gain fresh insights, extend their repertoire of skills, generate new resources—both from outside and from within the community—and apply those scarce resources effectively.

Universities have roles to play in each of these areas; however, these things cannot be done to or for communities—only by them. Local problems require local solutions. Through the right kinds of partnerships with communities, universities can make indispensable contributions to the process, insure in the meantime their own continued relevance, and gain access to value otherwise denied to them.

To maximize opportunities for success in these partnerships, portals to enter the community need to be selected carefully. In Genesee County, there was a special entry point into the community offered by the Mott Children's Health Center. It is a privately endowed institution that offers an array of direct free pediatric, dental, mental health, and developmental services to eligible children and families. Two years ago, a memorandum of understanding was signed between the health center and MSU. We agreed to form a partnership dedicated to a new framework for Genesee County of university/community interaction, one predicated upon the application of a community-driven co-learning process, which promises as a measure of achievement tangible and timely contributions to clinical practice, to community programs, and to public policy. We have identified three primary themes, selected because of their promise to positively affect community outcomes: 1) protecting at-risk children; 2) promoting youth health and development; and 3) developing coordinated care systems for children with special health care needs. We try to inform all of our efforts with a strength-based approach.

I will illustrate our efforts using a project from each of the first two theme areas, the first being protecting at-risk children. Among the center programs aimed at protecting at-risk children is a two-decade-old contract with the Department of Social Services (DSS), focused on providing education and counseling through mental health professionals to families referred to protective services for child abuse and neglect. This program was never formally evaluated. MSU was provided entry to patient records, where retrospective chart review produced some interesting results. They were able to identify characteristics of patients and families and examine some of the interventions. These results were presented to an audience of faculty, health center staff, and social service representatives in 1995. The group was so interested in the results that they generated plans for formal program policy rounds for 1996. At these policy rounds the audience is going to include state and local DSS officials, representatives from several foundations, as well as faculty and staff. We are going to outline a prospective evaluation of this program and seek funding for it. This is an example of a short-term project with truly long-term implications for program and policy.

The next example comes from the second theme area, promoting youth health and development. Among the programs aimed at promoting youth health and development are two high school-based teen health centers of which I am the medical director. These centers are staffed by pediatricians, nurse practitioners, a mental health professional, health educators, and receptionist/medical assistants. MSU teams have been engaged in teaching staff how to conduct focus program evaluation guided by questions generated by the staff members themselves. This has been a highly interactive process. The staff is working actively to put in place evaluations in several areas, including comparative efficacy of schools and doctors' offices for assuring completeness of immunizations such as hepatitis B, the roles of medical assistance in school-based and office-based sites, and the use of schools for delivery of mental health services. This then is an example of capacity-building and staff development with obvious potential relevance for managed care.

In both of the examples provided, the problems selected were identified by community staff. Evaluation is a common thread. Capacity-building plays an important role, and there are real prospects for tangible impacts upon program and policy. The partnership has had, and must continue to have, a "build the plane as you fly it" character. We have learned a number of critical lessons from direct experience. There is an emerging literature about community/university relationships, but these are things we have learned directly. At times we seem to have designed a plane with a wheel on the roof, or perhaps we have put a wing on a bit too loosely, but the flight seems to have leveled off for now. The primary lessons we want to share are the following:

1. Pick a project that promises early success, in order to assure staff and faculty that progress is possible and even desirable, and to generate momentum.
2. The cultures and corresponding pace of community agencies and universities are vastly different. As I put it, the intricate university ballet must meet the down-and-dirty community boogie on the same dance floor, and new steps and a common language must be learned by both partners. The differences between the community professors, the staff, and the campus professors must be minimized, and boundaries between them blurred. Similarities must be emphasized. To wit: each partner has special vital knowledge to share. Physical presence of senior faculty in the community is critical in order to build relationships and mentor students, and community staff must have a presence on campus as well.
3. Top leadership, presidents, CEOs, and so forth must demonstrate reciprocal commitment to the endeavor publicly, and suggest that commitment will extend over time, since progress will rarely be as rapid as one might hope for.
4. Isolated projects will not engage either community or university for long, nor expand the partnerships. Only work toward a common agenda of community-building, and system reform and integration, will sustain long-term interest and support on both sides.
5. You must have coordination. The partnership coordinators must have a relationship marked by candor. Confidential sharing of the strengths and weaknesses of our institutions helps bring a sense of reality to our discussions and planning, helps explain progress when it is slower than we expect, and helps brainstorming and problem-solving among us. It breeds absolutely essential mutual trust and respect.

Plenary II

6. Coordination of activities and projects must be meticulous. Carefully planned co-managed conferences, learning sessions, and special visits win confidence, but unanticipated appearances, or failure to show up or produce, rapidly erode sometimes fragile good will.

7. Despite best efforts, such partnerships and the mutual responsibilities they entail continue to represent, just beneath the surface, for many community members, agency staff, and university faculty an unnatural act. That is because the relevance of the ivory tower is readily doubted, faculty are often seen as voyeurs instead of fellow voyagers, evaluation is more readily seen as a weapon than a tool by community staff, and a sense of inferiority may be generated in community staff who may feed on the occasional arrogance of faculty. The slightest flaw may prompt a latent "I told you so." Hence, the coordination team must patiently and actively communicate expectations and benefits and celebrate those successes publicly and regularly.

8. New opportunities need to be continuously generated and explored by this coordination team. Timely trouble-shooting is absolutely indispensable in order to both expand the partnership and maintain those gains. Despite thoughtful planning, surprise, the unexpected, or overlooked should be presumed. Early intervention is critical.

9. Boundary blurring, which I have suggested before as vital, will not occur without rewards. Of course, the positive impact upon clinical practice on community programs and on public policy is the *raison d'être* of these relationships. However, community staff need faculty appointments, joint authorship, presentations at conferences, and cross-site, co-learning opportunities. Faculty need recognition and support for nontraditional off-campus work.

10. Long-term funding must be sought as a shared responsibility. Our experience has been that seed money is a necessary investment for the university rather than an unacceptable cost. However, in the long run, resources from within the community and from without will need to be collaboratively sought to provide sustenance for the efforts.

You can tell that I have enjoyed this partnership. It has brought the word "shared" to life in terms of ownership, mission statement, work plan, program policy rounds, scholarship, and responsibility for funding. This has been a true collaboration among conscientious colleagues who have value, commitment, creativity, competence, candor, and easy camaraderie, and all of this is dedicated to assisting Genesee County in its critical task of rebuilding the community and facilitating essential system change and integration.

Mark Schauer: I am here to talk about an emerging model in community-based interagency collaboration. Calhoun County is an urban/rural community of about 140,000 people. Battle Creek is its largest city of about 60,000 people. We have many urban problems and a complex community. In 1989, the Department of Mental Health provided a grant to help counties form what are called human services coordinating bodies. They were intended to help public agencies pool their knowledge, talk about prevention strategies, and jointly plan and tackle community problems. We brought together the public aid county-level directors of organizations such as mental health, public health, what we used to call the Department of Social Services, now called the Family Independence Agency in Michigan, the probate juvenile court, substance-abuse agen-

cies, and so forth. That was a synergistic process because it was the first time that many of these people had come together. The focus was on prevention and services to children and families. Such initial activities included infant mental health services, supports for low-functioning mothers, and substance abuse initiatives.

Originally, I was a member of the human services coordinating body as a community action agency director. Fairly early in its process, the group brought collaborative initiatives to the table. At the federal level it is called "Part H;" in Michigan, "Early On." Part H is an initiative to identify and provide collaborative supports to infants and toddlers with developmental disability or delay and their families. It is a collaboration that came from the state to our Department of Education, and it required a county to form some kind of collaborative body. An important decision was made by the Superintendent of Education in our community to bring that initiative to our human services coordinating body.

Other examples followed soon after. Federal mental health block grant money to maintain high-risk adolescents in their homes was brought to the table. Rather than forming another fragmented coordinating body to coordinate services, that was brought to the human service coordinating body. A teen-parent services project entitled "Strong Families-Safe Children" was another initiative. It uses federal block grant money, and in the era of block-granting, this is very relevant. We were being asked to put together a model at the local level. However, that was an initiative where the state required each county receiving those dollars to put together what was called a family coordinating council. In many counties, because of political turf, lack of communication, or lack of history of working together, these various councils were separated and fragmented. We brought that to our human services coordinating body and functioned as the family coordinating council.

The model of our organizational chart includes many work groups. We use them to carry out the work and the objectives of the human services coordinating body. The membership of our human services coordinating body has grown over time and as these collaborative initiatives have required. We now have 33 members. The core of six public agency directors are dwarfed by many private family service agencies, church community ministries, several consumer groups, and business groups such as the Economic Development Forum.

Recently, the human services coordinating body became a multipurpose collaborative body. The State of Michigan, through its own systems reform process and a decision of the state human services directors, decided that it wanted each county to have what it called a "multipurpose collaborative body," one body in each community where these collaborative initiatives would be pooled. In many communities, it was a highly charged, highly competitive process. Last October was the deadline for each county to declare what organization would be this multipurpose collaborative body. There are still some counties wrestling with this process; however, we became the multipurpose collaborative body for our county, raising the ante for sharing policy and outcome responsibilities for initiatives. Again, that is critical in the area of block grants because it allows for more flexible, more categorical dollars flowing to our community with some targeted outcomes on which to work.

It was about this time that our partnership with Michigan State University was formed. Our partnership with Applied Developmental Science started with a relationship that Hi Fitzgerald had with one of our human services coordinating bodies, and the critical term is "relationship." There was a reputation of credibility, trust, and a basis for negotiations for what this partnership should be. Timing was critical. We were just becoming a multipurpose collaborative body. We had some critical planning pieces on our agenda, and we realized that we could use some help

Plenary II

from a university perspective. We had developed the joint mission statement that talked about integrating investigation, intervention, evaluation, and policy, and we had developed a joint work plan that laid the groundwork for our work together. Top priorities were evaluating Strong Families-Safe Children, developing a neighborhood-based asset mapping process, and sharing resource development.

The most critical piece of the partnership has been the introduction of evaluation skills to our community. We have talked about evaluation and why it is important, but to have the kind of expertise that was brought to the table through the Psychology Department of Michigan State University has been invaluable. It has helped us focus, make coherent the various strategies and activities that we had talked about, and tie them to our outcomes. Often at a community level you have outcomes and activities, and maybe once in a while they meet or come together. Also, the increased understanding of the role and function of evaluation has been important to our local policy leaders. For our university partners, they have gained an increased awareness of the challenge of maintaining evaluation as an ongoing priority in the community.

MSU has been an important working partner and source of valuable expertise in this process. Faculty has served as outside experts when we have needed that—whether it be focusing and motivating us in the asset mapping arena or functioning as third-party objective consultants, offering insights and observations on our local systems reform process. The management committee that was mentioned has kept us on track for mutual accountability. This partnership has enhanced internal and external credibility of our process, and has given us a reputation at the state level as a model.

My final comment is that partnerships must be reduced to the individual level. That is how our partnership began. It is the basis for trust. You have to get beyond institutions and work together as people, hold each other accountable, and, importantly, do what you say you are going to do. That has happened for us. This has been an outstanding experience. I know our process would not be where it is today without this.

L. Annette Abrams: Please imagine a three-legged stool. I am going to talk about the third leg. One leg is university representatives. The second is community agency systems representatives. The third leg is the policymakers at the county and state level. We talk so much about being sure that research gets in the hands of those who make public policy decisions and allocate taxpayers' dollars. The fear is that if it does not, trees will fall in the forest, no one will be there, and no sound will issue forth. Policy will never be informed. That has been a major and ongoing challenge of our partnership.

Not only in Michigan, but across the country, major policy modifications are taking place—welfare reform in all its complexity and potential impact on children of all ages and their parents, local realignments and possible new responsibilities, block grants, and managed care. Underlying all of this for policymakers in state and county government are mandates that all shall issue forth with an emphasis on assets and strengths of families, clients, and communities, and be based on reliable outcome evaluation.

We are working with a policy group, project by project, that frankly is overwhelmed and quite terrified that they do not have a grasp of the state of the arts that they need. At Michigan State University, we target the executive branch as the policymakers—the rational arm of government, more rational than the legislative branch. We are very clear that departments on the state and county levels have personalities. Therefore, the way that we engage our policy colleagues varies, based on the personality of their agency, from education to social services to mental health

to public health. Our philosophy of policy engagement is that policy staff become stockholders in our work, not just stakeholders. We put them to work. We ask them in at the beginning of a project. We talk about our overall identified project goals and shared questions from both the university and the community. We invite them in with the same rules of engagement that we lay out for our community partners. We co-design, co-learn, co-implement, and co-fund. We are pleased to report that they accept those responsibilities, at least they have so far in the projects in which they have a presence. This is labor-intensive work: fanning out to brief the appropriate people at the state and county level so that you have people supporting your work and not feeling you are coming at them from the side, undermining them, potentially threatening to put in the headlines of the *Detroit Free Press* adverse evaluation or research findings. Policymakers become project team members, and in that role they roll up their sleeves and work equally with us, culminating annually with this process of program policy rounds.

Now, what is in it for them, we ask. Several rare commodities. First, nose-to-nose interaction with community people. When you get in these systems, you do not get out much. You are guessing about community needs. You are looking at spreadsheets and you are not looking people in the eye. Second, they have easy access to colleagues at the university who provide a variety of things that they need as policymakers. Third, they have cross-site access. And lastly, there is seed money from all partners so that the burden of diminished research budgets is relieved a little because we are all chipping in a fair share.

Lessons learned: first, this process allows us to get beyond the stereotype that policymakers frequently have of universities, that we are entrepreneurial people in the business of doing research with no resources to do it. It is such a shared process that we can use the F word—funding—without breaking out in a cold sweat. It is part of the process. It is a legitimate question.

Second, policymakers need a lot more than just research and evaluation. They need asset training, that instructional outreach that the university has to offer. They need database development, consultation, program design information, access to a whole menu of expertise at the university.

Third, it is best to have our community/university partnership strong, honest, and productive before we bring policy people in. They should join a smooth-running group rather than be a part of working out all the early glitches and understandings.

Lastly, the program policy rounds that were described are a valuable part of our process. They insure accountability; they keep us on track. Foremost, they allow us to bring our respective constituents to the table to say, "Let us share what we have learned, critique what we have done, and look to the future for the important longitudinal work that we co-design and that will benefit all of us."

Willie James Epps: The second partnership involves the Margaret Cohen Head Start Center and the University of Texas at Arlington. This is a six-year effort funded by Texas Instruments.

Mary Fulbright: Margaret Cohen Head Start Center is the direct result of a strong organizational partnership: Texas Instruments Foundation (TI) initiated the original research that led to the development of the Margaret Cohen Head Start Center. TI provides team leadership, especially in the areas of goal-setting and accountability procedures and continues to provide major funding. Head Start of Greater Dallas administers and manages the center and provides the services on a day-to-day basis. Southern Methodist University designed a special language enrichment program for the Head Start. SMU trains the teachers and supervises volunteers in the language enrichment

Plenary II

program. The University of Texas at Arlington conducted the original research, designed the Margaret Cohen Head Start model, and conducts ongoing evaluations. Representatives of the partnership meet quarterly and as needed. We have an ongoing cooperative communications system within the partnership, but the focus of the partnership is the whole child in the context of the family.

Margaret Cohen Center is located in inner-city Dallas. The Head Start serves 90 children, 90% of whom are African American. About 90% of the parents are single heads of households. Seventy-five to 85% live in public housing projects. Less than 30% of the parents are employed. Fifty percent did not graduate from high school. About 70% of all of the families have an annual income of \$5,000 or less. In enrollment, 92% of our families were receiving some kind of public assistance.

A multidisciplinary team provides the full array of services; staff includes two social workers, a full-time nurse practitioner, and five teachers and five assistant teachers. The evaluation component conducted by UTA documents success in achieving the goals of the center and identifies areas of weakness that need to be addressed.

A nurse practitioner gives or secures all of the health services. Children's health care at Cohen is equivalent to that of children in more affluent families. This includes a full physical examination at the time of enrollment and discussion with parents of the child's condition so that the parent becomes completely familiar with the child's health condition and learns of any particular problems that need to be addressed, or where special care is needed. Additionally, every child receives an audiological exam and vision screening. All children have a total dental exam from a dentist, following which cavities are filled, teeth cleaned, and sometimes bones repaired. The instruction in oral health is one of the major components in the health care component. The nurse continues to observe the children after the physical on a day-to-day basis. The nurse practitioner achieves 100% of the goal of providing or securing all of the health care that the children need.

Two social workers (caseload 1:45) focus on family needs, helping the parents identify their own goals and then achieving them. Employment, job training, and education are primary goals identified by the parents in the initial needs assessment. At time of enrollment, 29% of parents were either involved in employment, education, or job training. Through the direct cooperation of parents with social workers, by the end of the year, 63% of the parents were employed, going to school, or in training. At the beginning of the year, 14% of the parents had full-time jobs. By the end of May, 32% had full-time employment.

The involvement of the parent in the child's education and development is critical. At the beginning of the year, during the first month, parents contributed 69 hours of service at Cohen. By the end of the year, 227 hours were contributed by the same number of parents. Parents' involvement with their children enhances their children's self-esteem. Parents are able to provide a more stable living environment that will have long-term consequences for themselves and their children.

Mike Rice: Our collaboration is held together by faith and trust, as has been stated by the people at Michigan State. We have an added ingredient named Ann Minnis. Ann Minnis is what makes our collaboration function. She inspires, coerces, wheedles, and embarrasses us into continuing to work in a constructive manner at all times.

I have five points to make. First, intellectual capabilities of the children who live in Dallas in poverty are far less developed than is generally believed. The inherent capabilities are there in

the child, but they are not brought out by the environment in which the children exist. When children come to the center, they are given the Peabody Picture Vocabulary Test. The norms for all children in the United States are that four-tenths of one percent of the children are in the bottom first percentile. Sixty percent of our children are in the bottom one percentile. That is about 150 times the number of children at that level than one would expect. This is a dramatically bad situation. The clinical evaluation of language fundamentals shows an equally poor distribution: far too many in the lower end, far too few in the upper end, and a long way to go to achieve a normal distribution. In the Battelle Developmental Inventory, all cohorts have the same patterns. The children are 13 months behind in personal and social development, and 8 months behind in adaptive functioning. The board of the foundation was more than surprised; they were shocked.

Second, without a significant intervention, these children are unlikely to catch up in intellectual development. The right goal in the education domain for Head Start is for children on average to enter school at grade level, with chronological age and developmental age the same. If you want to get aggressive, make it 100% at or above average. But first, average.

Third, I would like to discuss how we are doing at Cohen with the intervention and what kind of results we are getting. First, for the PPVT, we have moved toward a more normal distribution, but it still does not look like the classic bell curve. This assessment tests more than just receptive language. It assesses other skills, and when the other skills are brought into play, the children do better. In terms of the Battelle, there are enormous gains in personal, social, and adaptive functioning, and also some gain in motor development. However, the children are still falling further behind in communications. There is a gain in the cognitive domain, and a strong gain in an overall sense, essentially up to the norm, but not in a balanced way. The conclusion is that we are not yet meeting our goals, but we are moving in the right direction. The board of the foundation was shocked when they saw the first results where the children were in the 20th percentile on a nationally normed test. This was very disappointing, but through partnership, we found people to help us at SMU. We installed a language program that was created by SMU specifically for children who have language difficulties based on their environment.

Fourth, let us look at how the children are doing when they leave Cohen and go into the public school system. We have five years of kindergarten ITBS scores. In the Dallas public school system they use the ITBS at K, one, two, and then the TAS (Texas Assessment of Academic Skills) test at grade three. Over the five years, there has been dramatic improvement in the performance of the Cohen children. If one is at grade level, or at the national norm, one needs to be at the 50th percentile. By the third cohort, the children reached 50%. The fourth cohort was well above 50%, as was the fifth. These cohorts of children who started out in the bottom one percent in the development of their intellectual capability have now moved up to the 60th or 70th percentile after kindergarten in the public school system. That is major movement over just two cohorts.

Head Start should adopt a goal of having children at grade level, on average. We should have evaluation programs in place to assure that we are accomplishing this. We should direct our research in the educational domain and specifically target this goal. But let us not forget that the public school system is an important player.

Wanda Smith: Due to the great results we have had from the model and the partnership with TI, the UTA, and the SMU, Head Start of Greater Dallas has been able to adopt some of the programmatic initiatives that have proven successful. First, the agency has been able to hire three nurse practitioners that have increased the efficiency of our health component, as well as provid-

Plenary II

ed some cost savings that we could then move to other programmatic initiatives. Second, we have reduced our caseloads for social workers to about 50 or less. That has certainly increased the efficiency of the social services component in terms of moving families toward self-sufficiency. Third, we have established site-based management or decentralization. As a part of our long-range planning process, we plan to have our center directors provide the leadership for the entire program in each of their communities. Last, our education advisory committee, as well as SMU, is currently working on a revised version of the language-enriched curriculum that we will institute throughout the program.

Ron Herndon: We have heard about collaboration and intervention. Both practitioners and policymakers will agree that both of these efforts work. Beyond that, I have a couple of comments.

All of us are going to have to extend what we do, extend our vision, policymaking, and practice to the low-income families we work with. Case in point: the families that we work with historically are families that come from communities that do not do well. This is nothing new. A friend of mine says it is almost like taking a barrel and filling it up with grease. Put grease on the inside of the barrel, and then historically put certain communities inside that barrel. That barrel is filled with misery. We look at those communities and say, "Oh, aren't those miserable people." Every now and then, one of those people, through almost insurmountable courage or whatever, is able to get over the edge of that barrel, and we look at them as the successful ones. Let us study those people because they have strengths. Let us study the other ones because they still have deficiencies. Perhaps we can come up with interventions that will help some of those that are in that barrel, that have developed self-destructive behavior, do not do well in terms of education, do not do well in terms of housing. I think you get my point.

At a certain point, those of us who are working with those families have to help them examine why the institutions that historically do not work well for them work well in other communities. Instead of trying to always come forward with different forms of intervention, which are necessary—Head Start is one of them that works—let us figure out why you get put in a barrel to begin with. Is there anything that these communities can learn from our research that will keep another generation from being put in the barrel? What can we do about the education system? Other communities do not have to have these intensive intervention efforts. How do education systems work well in other communities, not only in this country but around the world?

I like the example of the shot to the moon. When they got ready to start the rocket program in this country they did not only rely upon scientists from America, they got scientists from countries all around the world who knew what they were doing. I think we need to do the same thing.

What is wrong with the financial and banking systems in these communities? Why are loans not available for people who want to buy houses or for people who want to start businesses? Why does redlining still continue to happen in these communities? What is happening with the housing stock in these communities? Why has more housing not been made available for low-income families? Why does the banking institution not come up with more flexible ways for these people who work hard to become homeowners?

What is happening in the area of employment? Why are there extraordinarily high levels of underemployment in these communities? Is it just because all of the people are unqualified?

My point is this: Why does government not work in these communities as it does in others? No matter how successful we are with a certain number of these families, unless we begin to help their communities come up with this kind of analysis about what works in other places and why it

does not work here, we will not get anywhere. Show them examples of low-income communities that have been successful in modifying the behavior of these institutions so that they are now working successfully with these communities.

We do not have to look only at low-income community examples in this country. Let us look around the world. Take child care as an example. Child care works well in middle-income and upper-income communities because they have money. If we restrict our examination to this country, we are going to lose some successful examples of how low-income communities around the world function well.

Last, if we do this, along with everything else, collaborations make sense and interventions make sense, but we have powerful research engines available all around the country. If we do not help communities come up with this kind of examination about why they are in the barrel of misery, what can be done, and who has gotten out, how are they going to be able to get out? Who helped pull the slats off the barrel, got rid of the grease, and is able to maintain healthy, functioning communities generation after generation? If we do not provide that information to these communities, we will always be coming together as researchers and practitioners saying, "Look at them in that barrel of misery. This is what I am doing to help them collaborate and this is what I am doing in terms of intervention." If we only do that, we are being voyeurs. We should be trying to work ourselves out of that position.

Lonnie Sherrod: I find both this conference and the partnerships just described tremendously exciting. Several times I heard people, particularly those of you who represent the Head Start community, state that when you entered your partnership with researchers, you entered with a distrust, even a dislike of researchers. I do not know how we have regressed to the point where there is such a separation between the research community and the rest of the world. However, it is extremely encouraging and exciting to see the partnerships that are represented at this meeting and in this symposium.

Now, having said that, the most important thing I can say is simply grow, prosper, and multiply. I have just two points I want to make that have to do with the nature of research and the nature of partnerships. Those of you who work to accomplish social change, whether it be through Head Start centers or any other social intervention or program, are at heart researchers, whether you admit it or like it or not, because usually you are operating from some implicit theory of change, of how you can help children and families or how you can accomplish some social change. Therefore, one important contribution the research community can make is to give you the tools to make those theories explicit and to evaluate or test them. This is not my idea. There are a number of researchers such as Heather Weiss, Carol Weiss, and James Connell who are writing about this and trying to lay out the implications of this fact for the research and evaluation of programs like Head Start.

Having said that, that is not the most important point I want to make about the role of research, because research is learning. You should embrace your partnership with researchers in order to learn about the process of what you are doing. Certainly, evaluation of your program and the accountability thereof is of paramount importance. If the evaluation can be an experimental design, that is even better, because that is the clearest way to attribute causality to what you do. However, you really want to learn about what works in your program, how you put it together, how the social change that has been talked about impacts on your program.

As an example of another kind of learning, four histograms were presented of evaluation results, comparing the Cohen group of children with a comparison group across four cohorts. It

Plenary II

was in the third and fourth cohorts that there were statistically significant differences between the two groups. However, what you may also be able to see from these histograms is that the four cohorts all show substantial change in a positive direction. The difference between cohort 1 and cohort 4, in both the experimental and the comparison groups, is as great as the difference between the experimental and control groups in cohort 4. All children are getting better. In some cases, these kinds of things wash out your experimental effects; in this case they do not. Clearly, the Cohen staff is making a difference. However, it is important to understand that something is happening in that community that is helping all children that is probably as important as the program efforts. We need to use our research efforts to learn about them and not get caught up in the fallacy of searching for magic bullets in the form of a single program or a single intervention. We need to ask how efforts within a community accumulate across those efforts and across the age of the child.

I was at a meeting in New York City last week of full-service community-based schools. They saw themselves as a partnership among various community-based organizations: parents, teachers, and the school board. They described a developmental progression in their relationship: from being a linkage in which you simply pull together the pieces, to being a collaboration in which you cooperate and consult with each other, to being a full partnership that involves a kind of "give and take" relationship between the different stakeholders in the partnership. They compared the partnership to a marriage, and I could not resist pointing out that most of the marriages I knew were more like linkages than partnerships. The important point is that there is a developmental progression here. We understand very little about the development of these kinds of relationships—about what works for whom, when, and under what circumstances—and how much that kind of progression from a linkage to a partnership may benefit the partners. In addition, what benefit does it have on the children, or the stakeholders, the recipients of what is being delivered through the partnership?

I hope that we will set up partnerships with the research community so that we ask those kinds of organizational, social, and institutional questions as much as we ask questions about the impact of the specific intervention or program in which we are interested.

Translating Research into Practice

Chair: Deborah Phillips

Presenters: Roy Peterson, Jeff Stoddard, Deanna Gomby, Gregg Powell

Closing Remarks: Esther Kresh, Juanita Santana, Merrily Beyreuther, Ann Linehan

Deborah Phillips: This is the third plenary session on translating research into practice, and it is difficult to imagine a more fitting conclusion to this exciting, information-packed conference. The panel personalizes the theme of practitioner, researcher, policymaker partnerships that has been the umbrella for the conference, as well as for each of the plenaries. We have four speakers today, each with extensive experience bridging the worlds of research, practice, and public policy. They also bridge issues of health, early education and welfare, and early intervention. They come from diverse vantage points: a community health center, a university-based medical school, the National Head Start Association, and a foundation.

Gregg Powell: One of the questions we keep hearing is, "Does it work?" After a number of the presentations we have heard here, we can all agree that it works. What we have not agreed upon is what "it" is, and what "works" means. We have at least agreed on what "does" means.

The diversity of Head Start has always been one of its strengths, and the fact that not every program is alike is something that the National Head Start Association has long learned to live with. In 1990, the Head Start Association released its Silver Ribbon Panel Report. That report called for an increased role of research in the program, after a long period of little or no research. We like to think that that played a major role in the eventual increase in research in the Head Start community. We asked then for research to explore the effect of quality variables, particularly those related to staffing, training, and program content. That is being done under the guidance of ACYF, and with the encouragement of our offices. Other research topics include the effects of various services on particular families; the impact of Head Start on parents, the family, and the community; the effects of multiple years of services; and approaches to and effects of serving children at a younger age.

I want to look at what the National Head Start Association has done and will do in the future to promote research that helps inform practice, and practice that helps inform research, and look at the areas where we need to put our efforts. Our first step was to establish relationships in the research community. We have managed to establish a relationship with SRCD, and I will attend the American Psychological Society conference next week. We are also making contact with other organizations. However, most important is what we do to encourage the partnerships between practitioners in the field and researchers. Our organization works with regional and state associations, and I am proud to announce that almost half of them now have research and evaluation committees as a part of their functioning boards. What we want to see next is those committees starting to work with at least one major university in their area. We would like to see that extend to the state associations. We already have major efforts going on in states.

Dissemination has long been an issue. How do we get the information we have out to the programs? We have a great deal of information already, but it is not in a form that is usable by the practitioner community. Through a collaboration of end-users, technicians, and engineers, we developed a user-friendly computer system that made it easier for nontechnical people to use

Plenary III and Closing

technology. That is the kind of partnership that is starting here so that we can eventually have a user-friendly way of accessing research. One of the areas that we are looking at is taking existing information and translating it into what we call "recipes for success." Basically these are recipe cards that can be put out in the centers that say, "For this particular practice, here is what the research says, and here is how you might be able to put that into practice in your classroom."

Another aspect is disseminating the results of research more widely. There are thousands of journals that publish relevant articles. It is not realistic to think that a Head Start Director, much less a Head Start teacher, could subscribe to each and every one of those journals. We need more ways of getting the information to the field. In that effort, NHSA is beginning its own research quarterly. The first issue will be devoted to our research track at our own conference. While this conference focuses on researchers and practitioners together, ours is a little different because we talk to practitioners and parents themselves. I encourage any of you to answer our call for papers. Our quarterly will ask researchers to talk about the implications of their findings for practice, and also ask practitioners to respond.

Roy Peterson: My story is about Flint, MI. If teen pregnancy, youth violence, infant mortality, lack of academic achievement, and poverty are poisoning our children, then our community may qualify as one of the ten most toxic dump sites in the country. Until recently we did not talk much about these things. We never linked them together, never put them in a package. They are sources of shame, reasons to blame. We needed to create a response to that shame and blame, and a vision about what to do.

In our community in the late 1980s, we realized that the battle was bigger than the size of our army. We needed new recruits. The need for coalitions and partners is clear. In 1990 we created an advocacy mechanism called "Priority Nineties: Children and Families" and set out with five modest but difficult goals: 1) to monitor outcomes; 2) to inform the community of what those outcomes were and help the community set priorities; 3) to identify projects and programs that were doing a good job to respond to the legitimate needs of the community; 4) to maintain a dialogue with decision-makers; and 5) to celebrate successes.

We required a model to get the job done, codified a Priority Nineties paradigm that begins with knowledge. That is your work as researchers in large measure: knowledge first and foremost. In our case, knowledge was a data set that we synthesized from existing banks in two dozen offices in our state capital. At that point those data sets were not interactive; they were not coordinated. However, hard data alone does not comprise knowledge as we needed it. Case studies put a human face on some of what we measured. Focus groups gave us background and context as to why the facts were so bleak, but more than data was necessary. Awareness was the second step. We needed to transform information into awareness. The knowledge we brought to the community to create awareness was through community meetings, media, and network-building. In general, we tried to seek out people to share our interests because we wanted to go on to the third step: building concern by linking common interests. Study groups put fingerprints on our results, on our picture of what the community looked like, and what it could become. We needed broad involvement if we were to make an impact from family rooms to boardrooms. That led to a three-pronged action: 1) influence funding; 2) analyze policies and systems and target decision-makers; and 3) celebrate our successes. We knew that human nature would have us just wither and go away, so we needed to take advantage of those instances where we could win a couple and celebrate successes. We sought to become comfortable with the phrase, "We are pleased, but not satisfied." That is our Priority Nineties paradigm.

The group working at getting this job done was made up of over 100 community leaders who met regularly. It was a politics of inclusion, not exclusion. We involved people who wanted to be involved, but more importantly, we tried to balance the composition to include membership from the political, business, civic, consumer, and provider sectors. You cannot have a dominant point of view and come up with a balanced agenda for your community. The entire group met periodically, with regular community meetings scheduled to get the work done behind the scenes. Our health center picked up the cost of mailing, secretarial work, printing, and some consulting work, but we required a modest outlay of about \$30,000, within the reach of most communities. Six years later the Community Foundation, United Way, Rotary Club, area banks, and utility companies have joined our center to expand our initiative to a \$150,000 per year commitment.

What are we doing with the money? Our membership services actually are part of feeding ourselves. We feed ourselves through a newsletter that keeps us abreast of developments in our community. We also have a community grants alert and proposal endorsement process. We felt that there was a competitive advantage in being able to speak as a single community voice rather than as competing agencies going for the same pot of money. We have an Internet web site that enables people to access the Federal Register, secure information about our community, as well as positions we are taking. We established prevention as our initial emphasis, the first project being immunization. An effective example of how we made an impact is that an executive from the telephone company was moved by the immunization issue and said he thought he could help. Two months later, about 200,000 people received a note with their telephone bill concerning the importance of immunization, the schedule of immunizations, where to get them, and so forth. That kind of networking is within your reach.

In cooperation with the Children's Defense Fund, we started a child watch program called "Through a Child's Eyes." Typically, the Mayor of Flint and the Chairman of the County Board of Commissioners would welcome 25 or so elected political leaders to participate in a half-day, person-to-person experience with people in need. These were people who had the kinds of problems that get measured and reported as cold facts, that researchers get enamored about. However, we needed a more personal view of that data. We collected the elected officials at about 8:00 a.m., put them on a bus, and gave them a guided tour of their community through a child's eyes. We took them to an education center for high-risk youth that housed a day care center and a Head Start program. We talked to staff, teen mothers, and little children. The officials were able to put a face on the statistics that they had heard earlier in the morning. As we were walking out of the center, one of the judges turned to me and said, "This is the first time in my life that I have ever understood the importance of child care to education." From there we went to an inpatient service center for emotionally disturbed and sexually abused children. It was a gripping visit, and helped the political leaders understand in their gut what they knew in their heads. We ended with lunch at a soup kitchen, talking to some of the homeless about the services there. We heard a compelling story from a 21-year-old woman, a junior in college, who said the choice she faced when her husband walked out was to keep her house or continue her education. She felt that in the long run it was better to go to school. She lost the house, but the temporary shelter was allowing time for her and her children to make permanent arrangements. We made a profound impact on the community leaders on that visit. Child Watch programs like this, each a little different, each with a different composition, occur four or five times a year in our community.

A third area is public information and attitudes. This involves media relations, community forums, and a speakers' bureau. For instance, we were the only place in town where two mayoral

Plenary III and Closing

candidates came to talk about issues. We asked them to speak specifically about child and family concerns in our community. We sponsored debates for state legislators and congressional candidates from our districts, and we learned about the rhetoric of family values. We are now looking at business attitudes and the information that business has about child care and family-friendly policies. We do not think we can turn the corner in our community unless business understands the relationship between what it does in human resources and children and families.

The final area is policies and systems. We have consistently issued position papers supporting comprehensive health education and antismoking regulations, testifying to the Senate Finance Committee, U.S. Department of Agriculture, County Commission, and Boards of Education. On policy matters we have linked with state advocacy groups, the Children's Welfare League of America, and the Children's Defense Fund to extend our positions to state as well as federal levels. We have a report card based on a detailed technical report that is widely distributed. It provides some standard data for the community and saves everybody a lot of time. We also have a biweekly newsletter that is distributed by fax and mail. We have appeared on the editorial page of our local paper between 15 and 20 times in the last couple of years. Our point is if you feed the media regularly, it is less likely to bite you. If you take care of it, it can be a positive and necessary influence in your advocacy.

From our standpoint, we want you to make certain that you collect and report your accurate data. Present information in an interesting, understandable, useful, and comparative way. I told the Superintendent of Education that his immunization rate was 83%. He thought that was great until I told him that he was 19th out of 21 school districts in our county; then he understood. If your data is meant to influence policy, do not present written information to impress your colleagues. Some people respond to numbers, some to words, some to pictures; use all three if you can. Resist the temptations of overstatement, overselling, overwhelming. When we produced our report card, it showed Cs and Ds. We wanted to tell the community that we would change these grades in a heartbeat. Instead, we told them honestly that in the next couple of years things might get worse before they get better. Promise only what you can deliver. Thank and give credit to your data sources and partners if you want to use them again. That is one of those things that often gets lost by researchers. With the power of partnerships comes a broad, diverse power base to collect and present your information. Have providers and practitioners help you with your data collection and analyses, but involve other stakeholders as well. A balanced coalition will ensure candor and integrity in the process. Give drafts of your material to your friends before you go public; give them time to react before you go public. Otherwise, you are going to find that your friends disappear, and you are going to have a hard time convincing anyone.

Look at outcomes without placing blame, whenever possible. Data prompts questions and discussion. Let others work at conclusions and solutions with you. The power of your data comes in large measure from the power of your coalition. Act to maintain unity. Take time to listen to all sides, not only to those who agree with you. Do not be limited by your comfort zone or by professional snobbery.

Affecting policy is a process that is sailed, not driven. That sounds a little New Age, but when you think about it, driving is a hands-on medium; you see the road in front of you, steer around the potholes, and react to every single stimuli. Influencing policy and sailing require a different approach. You see a harbor, know where the wind is blowing, know where the current is coming from. Boats are approaching. You know where you want to go even though there is not a center line to follow. However, it is not steering around every bump. In coalition-building and the

kind of policy-setting that we are talking about, you do not have the time or ability to do that. You work with the available elements to reach your destination.

For those of you who believe that data and rationality rule policy, I ask you to recall the 1992 Presidential election. One of Clinton's strategists came up with the idea to wear a button that said, "It's the economy, stupid." I ask every researcher in the audience who wants to affect policy to repeat after me. "It's right brain, stupid." If you have your data straight, you have to start thinking and working the nonlinear side of your brain. Think about self-interest. Start thinking about emotions as part of getting policy implemented. Writing good policy and getting it in place is very personal work. Reduce your data to yes/no propositions whenever you can. For instance, "Senator, we are spending \$.96 of every health care dollar on treatment and \$.04 on prevention in our state. Is that something you support? Yes or no?"

Strategize beyond your area of interest and influence. Identify potential partners. Look for related trends. In our community the current issue was educational outcomes. The business community was worried because their new employees could not compute and communicate. The businessmen went to educators to talk about how to get better-trained high school graduates. High school principals said if junior high schools sent us better students we could do a better job; junior highs said if elementary teachers did a better job, we would be okay; and kindergarten teachers said, "Have you ever seen what is coming to school nowadays?" We created a bumper sticker that said, "To School Ready to Learn; To Work Ready to Earn." We helped extend this continuum of interest. From there we made the case of the relationship between educational outcome to health to early intervention to prevention. We knew where the force was coming from. We deflected it in a way to make sense to a larger community, and it broadened the discussion and our network.

Our project is still in progress. Expect if you hear from us in the future that things will not be the same. As we are successful in promoting change, we must be nimble enough to keep up with it. The noted philosopher from the University of Chicago, Mortimer Adler, said, "The greatest gift that a person can receive is a job worth doing." If that is the case, you are truly blessed. Organizing the village to raise our children is worth doing, and it is a job worth doing well. Another eminent philosopher, an Italian philosopher, Lee Iacocca, said, "As far as kids are concerned, you can lead well, you can follow well, or you better get well out of the way." Good luck to you, and good luck to us all.

Jeffrey Stoddard: The effective translation of research findings into policy and practice is a daunting but crucial task. The very term "translation" in this context is a revealing one in that it implies difference in language.

Researchers, with an eye toward public policy issues, may well feel frustrated if their findings are not readily understood by policymakers, program administrators, and service providers. On the other hand, practitioners and policymakers may be equally frustrated by researchers who do not frame their research questions in ways perceived to be relevant, and who may not be capable of presenting their findings without lapsing into technical jargon. These remarks are intended to help researchers, policymakers, and practitioners understand one another's paradigms, language, and culture, and thereby communicate more effectively with one another.

As a starting point it is important for us all, no matter our discipline or background, to recognize that many researchers, policymakers, and practitioners from a variety of disciplines share a strong interest in improving outcomes for young children. In turn, each of these groups can uniquely make important contributions. Policymakers can provide funding for programs and for

Plenary III and Closing

research, as well as influence the structure and the effectiveness of programs by setting up outcome expectations and procedural requirements. Those on the front lines of implementing early childhood intervention programs, be they education specialists, local program administrators, or health care providers, can implement programs in such a way that they may be then destined either to succeed or to fail. Researchers, in turn, have the ability to assess the needs for new services, the quality and outcomes of existing services, and the specific reasons for success or failure on the part of individual programs. The development of ongoing partnerships between these groups seems not only mutually beneficial but imperative for the long-term success of early childhood intervention as a societal undertaking. Unfortunately, the forging of such partnerships is difficult because these groups operate in different cultures and have communication styles that often seem incompatible.

In a well-written article published in the winter of 1995 in *The Future of Children*, Anita Zervigon-Hakes outlined the respective roles, communication styles, and interests of public policymakers and researchers. In this article she indicates that elected public officials, appointed policymakers, and career policymakers all tend to depend heavily on newspapers, television, short issues briefs or summaries, and government reports for their primary sources of information. Researchers for their part are more inclined to rely on technical journals, technical books, and academic conferences such as this one. Researchers tend to have difficulty in expressing information briefly. They will use technical language and, in most cases, be relatively narrowly focused in their discipline, concentrating on one branch within their field. Policymakers tend to be more interdisciplinary and less technical in their thinking. They worry about short-term economic consequences, cost effectiveness, population-level impacts, constituent issues, public interest perspectives, and special interest impacts. Most policymakers expect quick response, as they have short time spans to accomplish their objectives. Thus, the receptivity to new research findings is maximized early in their term of office, with diminishing interest thereafter. For this reason policy-relevant research, already completed and on the shelf, may have the best chance of being translated into policy. Researchers, on the other hand, need time to conduct quality research and are often unable to expedite this process. This phenomenon is sometimes sarcastically referred to as the leisure of the theory class. Once their research is completed, many researchers may fail to understand that the window of opportunity for public policy impact of their research findings is no longer open, or that there may be some time interval before the window opens again. Moreover, the research question asked by the researchers is quite often more likely to be that which is scientifically answerable rather than being precisely the research question of greatest interest to the policy audience. This may reflect the availability or the quality of data. In many instances, a policymaker's interest in changing or creating public policy is prompted by anecdotal reports offered by concerned constituents more so than by research findings. For many elected officials, reality is defined largely by opinion polls and by the public's perception of an issue or problem as opposed to what more objective data may reflect. Still, fair-minded policymakers and those on the front lines of program implementation and service delivery often have a keen interest in legitimate, academically sound research. Their interest in such research may, however, come after their interest in, and even their views on, a topic have already been established.

How then do policymakers encounter and use research findings? They are unlikely to read original research or even scholarly reviews directly in an academic journal. Instead, they are more likely to encounter it as summarized by a staffer, or as reported in the media by a constituent or an advocacy group. In some cases, learning about a study from one of these sources may convince an elected official that the topic is one of some importance. In many of these instances poli-

cymakers will seek out researchers, in which case researchers then have the opportunity to provide useful and usable information to the policy audience. Researchers in these instances must remember that policymakers will probably be most interested in the broad picture and not in the details. Researchers must remember that in order to be effective in a briefing, they must be capable of summarizing the policy implications of the research findings succinctly and in a salient fashion. This environment is one that is not generally comfortable for most researchers.

Researchers advance in their professions on the basis of publications and winning grants and contracts to conduct new research. This is true whether they work as university faculty, in think tanks, or as research contractors for hire. In some respects, the skills necessary for success in these types of environments are 180 degrees in the opposite direction of the skills that lead to success for policymakers. For example, in order to publish frequently, researchers must become increasingly specialized. This is in stark contrast to the orientation of policymakers, who, by necessity, must be conversant in a broad range of issues requiring multidisciplinary and interdisciplinary approaches. Publishing in academic journals also forces researchers to communicate their relatively esoteric knowledge using technical language not readily understood by the wider public. Moreover, academic writing styles require attention to detail, as well as the ability to be extremely self-critical about the findings and conclusions of the research studies. These analytical skills result in communication styles very different from those of policymakers. Earnest researchers, in their attempts to be precise and to not overstate their findings, may often be perceived by policymakers to be wishy-washy or irrelevant. A former occupant of the White House, tired of economists telling him on the one hand this, but on the other hand that, was quoted as having said that he hoped one day to meet and be briefed by a one-armed economist.

The development of research questions of interest often begin from different starting points for researchers, practitioners, and policymakers. Typically, researchers consider solid research to be that which involves testing hypotheses in carefully controlled settings using well defined and distinctly measurable variables. Most policy-relevant questions are much messier than can be approached in this way. Therefore, from the outset, many socially relevant policy-focused questions may bode poorly as subjects for study for publication in the best academic journals. Historically, moreover, publications appearing in policy-oriented journals have been viewed by university-tenured committees as less important and less prestigious than publications in high-brow academic journals. With respect to study design, other fundamental paradigm differences also exist. Whereas all stakeholders may have a compelling interest in long-term effects of various interventions and may therefore support, in principal, longitudinal research efforts, most elected and many appointed policymakers must make their decisions long before longitudinal studies are complete. Similarly, practitioners routinely need to make implementation and practice decisions based on information currently available.

With respect to the interpretation of results of research, there are again fundamental differences. At the most fundamental level of all perhaps is the differing notion of what constitutes knowledge. Charles Lindblom and David Cohen in their book, *Usable Knowledge: Social Science and Social Problem Solving*, point out the differences between professional or scientific knowledge and ordinary knowledge. Whereas social scientists tend to question, minimize, or ignore ordinary knowledge, policymakers are often as inclined to rely upon it as heavily as they rely on their political instincts, and as practitioners rely on their experience. Indeed, many policymakers and practitioners may view social scientists less as allies and more as individuals who do little more than incrementally reshape and refine ordinary knowledge. According to Lindblom and Cohen, researchers also often neglect to recognize that findings from social scientific inquiry are,

Plenary III and Closing

in fact, moving targets. Moreover, they suggest the concept of the authoritativeness of scientific and professional knowledge is often misunderstood by researchers. In their chapter entitled "The Mistaken Pursuit of Authoritativeness," these authors state, "Let us therefore distinguish between the questions of whether a proposition is reasonably verified scientifically, and the questions of whether anyone will act on the belief or assumption that it is true." Professional social inquiry might establish as scientifically highly verified the proposition that children learn as well in large classes as in small ones. Yet no school superintendent might be willing to act on such a conclusive finding even though he knows of it, in agitating for new policies, in establishing class size in his schools, or in advising parents on the educational needs of their children. He may be skeptical or hostile to it for many reasons. If he is not willing to act on it, we shall say that however conclusive the knowledge is by scientific standards, it is not authoritative for him. It does not, in his eyes, warrant his acting on it. Conclusiveness is necessary but not sufficient for authoritativeness. Moreover, since scientific conclusiveness is a matter of degree, so also is authoritativeness. Thomas Thorstein Veblen stated in 1961, "The outcome of any serious research can only make two questions grow where one question grew before." This notion that our ignorance routinely grows along with our knowledge, while accepted by researchers, is often reviewed with frustration and cynicism by policymakers and practitioners who may view this phenomenon as an effort to justify the continual flow of research dollars. However, despite all the differences in skills, styles, and paradigms, policymakers and sometimes practitioners still do, in many instances, seek the legitimacy provided by objective research grounded in a scientific method. Society at large, including the public, the media, program administrators, and policymakers still view research findings published in major journals as impartial and trustworthy.

How then can researchers maximize the impact of their findings? Consistent with the title of this session, translation is the key. Who is the appropriate translator then? Public relations experts, the media, advocacy groups, and foundation staff all can be instrumental in interpreting and translating research findings and bringing them to the attention of policymakers, and in making the information more useful in shaping public debate and public policy. Many large universities employ media relations professionals whose full-time job is to translate complex research into language understood by the general public and to package the research findings into formats usable by the media. Professional associations and advocacy groups can also be instrumental in dissemination of research findings, as can foundation staff who may have supported research and therefore have strong interest, as well as ability, in distributing widely to the media and to a policy-oriented audience. When working with such translation and dissemination experts, researchers must remain attentive to proper interpretation of findings and must attempt also to retain spin control. Researchers must also remain researchers and not go too far over that line in becoming advocates if they are to retain their professional credibility among colleagues and peers. Researchers must not, however, delude themselves that research results can or should be devoid of political reality. Indeed, Jack Lindberg has said that research results must be informed with a little bit of politics and reality. Along with political reality comes a certain amount of risk for researchers who venture into this realm. For policymakers, and to an extent, for providers of service, as well, certain *a priori* expectations exist with respect to outcome-based research. These expectations include that studies will not be too expensive, they will be easily comprehensible, they will be relevant, and they will not show that the most expensive intervention is the best. In addition, most importantly, they will lead in the end to savings. Researchers must recognize and understand this frame of reference, and also must understand that many other factors besides research findings may shape or determine public policy formulation.

What are these other factors? The first of them can be referred to as social forces, which involve economic, market, social, and political factors that influence public and private decisions on resource allocation and use. The second major factor is existing regulations. This refers to laws and rules already in place that must be taken into account whenever policy decisions are considered, as their inertia can present a major obstacle to change. The third component relates to research findings. There may or may not be overlap or intersection between these three domains. Researchers who seek to have an impact but fail to understand the importance of the other two factors are destined to be frustrated, ineffectual, or both.

Zervigon-Hakes has outlined a number of recommendations for researchers who seek to influence public policy and practice. The following are a summary of the directives she laid out for researchers: involve career staff and appointed policymakers in the design and ongoing review of progress and review of final results of studies; conduct research that can answer practical implementation questions; communicate findings in easy-to-read brief reports and articles; provide research findings to career and appointed program staff members over and above elected policymakers; communicate data through various media; network with advocates, program administrators, and career and appointed staff to establish an identity as an individual with expertise; specifically commit time for research dissemination; work with interdisciplinary groups of researchers to design and think through policy implications prior to formulating policy recommendations; and finally, be patient but persistent, and be ready and able to brief policymakers.

Concerning the relevancy of research questions, I would like to lay out some points with regard to a research agenda. While the existing literature relating to early childhood interventions is rich, a few areas remain in need of further study. Most notable is the lack of community development approaches. Although most Head Start programs and other early childhood interventions are typically conducted in disadvantaged communities, most prior studies have not focused on the geographic neighborhood as a site of socioeconomic or psychosocial intervention. This shortcoming has seemingly led to a second, which is that many investigators, as well as policymakers and program administrators, are committed to the doctrine of comprehensive programs whose components are believed to be indivisible. This dogma is an obvious barrier to factorial designs from which it might be possible to distinguish the relative effectiveness of various components of a program. Clearly, the potential impact of research aimed at elucidating these issues is great. However, to successfully launch such research would require a major collaborative effort involving researchers, policymakers, and practitioners.

On a final note, I want to add that research can have its greatest impact when it moves beyond incremental additions to knowledge into the realm of fundamentally altering our understanding of major issues. We are now at the brink of this. A specific example of this is the work of Clyde Hertzman at the University of British Columbia. Hertzman provides a population health perspective to the area of child development and long-term outcomes. In a brilliant paper soon to be published in *Social Science and Medicine*, Hertzman pulls together research findings from a vast array of disciplines into a truly interdisciplinary theoretical model relating to child development and population health. Hertzman's interest relates to the impact of childhood experiences on subsequent health, well-being, and competence. His line of inquiry begins by pointing out that wherever it has been measured, life expectancy increases with increasing socioeconomic status. Moreover, the diversity of conditions of life seem to become directly embedded into human biology, such that human vitality can be directly affected by social hierarchies in a consistent manner across wide expanses of space and time. Hertzman cites many examples, which together suggest that high socioeconomic status provides a powerful buffer against both endogenous and exoge-

Plenary III and Closing

nous threats to successful human development, thereby suggesting a broad social policy corollary essential to an underpinning of Head Start. That is that those elements of high socioeconomic status that provide the buffer should be pinpointed, and ways found to provide them to children who otherwise would not benefit from them. Hertzman points out that there is consistent evidence relating to a variety of areas of function indicating that if appropriate stimulation is missed at a specific time in early childhood, function can be developed through other forms of stimulation later on in life, but that it is much harder to achieve. Thus, Hertzman applies the label "sensitive periods" as being more applicable than critical periods to human beings. Hertzman reviews both the latency model, emphasizing the prospect that discrete events tending to occur early in life will have a strong independent effect in later life, as well as the pathways model, which emphasizes the cumulative effect of life events along developmental trajectories and the ongoing importance of the conditions of life throughout the life cycle. Hertzman concludes with an admonition that nothing in the research literature would permit us to ignore the social context in which intervention takes place. He warns that we have no basis on which to believe that special programs can counteract deteriorating social conditions in general, especially at those ages when school and community influences begin to compete with the home environment as a factor in the child's life.

Deanna Gomby: I work with the Packard Foundation located in northern California. We make direct service grants in California, but we also make grants for policy, research, and evaluation purposes nationally. Today I want to talk about the publication of a journal, *The Future of Children*. I want to use the journal as an example of one way to transmit research findings to policymakers.

Let me start with the story of the journal. Our founder, Dave Packard, co-founder of the Hewlett Packard Company, was talking one day with my boss, Dick Berman, thinking about how our foundation could help move ahead policy on behalf of children and families in this country. Mr. Packard said that "policymakers and practitioners were often recreating the wheel, and it would be far better if we could put in one place at one time the best information we have about issues relating to children. That information could then be given to the people who make decisions about children's programs in terms of their design, implementation, and funding." That conversation led to our journal, which is published three times a year. The explicit purpose of the journal is to influence policy and practice related to children, based on an assumption that decision-making is inherently a rational, information-driven process. Senator Oren Hatch, a policymaker, says, "Those of us who are directly involved with decisions about policy are constantly in need of the best, most up-to-date, and most accurate information available. Knowledge is a crucial and nonpartisan commodity that is essential in guiding the policymaking process." This is the rationale for the journal.

Every issue of the journal focuses on a single topic related to children and examines that topic from a multidisciplinary point of view. Thus far, we have published 12 or 13 issues of the journal. We have looked at issues related to divorce, sexual abuse, adoption, and home visiting programs. A recent issue focused on "Long-Term Outcomes of Early Childhood Programs." The current issue is on "Special Education," and the next is on the "Financing of Child Care and Early Childhood Programs." We are able to distribute each issue of the journal, or an executive summary of it, to 40-50,000 policymakers. We send it to senators and congressmen and their staff, governors, and so on. We also include CEOs of Fortune 500 companies and directors of nonprofits.

The publication is designed to be somewhere between an academic journal and *Time* magazine. It is written in an educated lay person manner. This is not a tone that comes easily or naturally to many of the researchers who write for our journal. In writing for policymakers, shorter is better. When I was in graduate school, I took a course at the Stanford School of Business that was a little out of my element because I am a psychologist by training. The professor designed all the homework exercises to be helpful to people who were going to work in business. We had to write an issue brief about a certain topic, two pages double-spaced, no more. The professor believed that if you cannot do it in two double-spaced pages, you do not understand the issue. Furthermore, the CEOs you are writing for will not read it. Briefer is better. There is a certain amount of irony in my saying this, given that we distribute a journal that is thicker than two double-spaced pages. However, that has led us to put out an executive summary that we will distribute either in lieu of, or in addition to, the journal.

The second hint in writing for policymakers is to put the conclusions first. Again, this is not necessarily what academics do naturally. Think about the policymakers who have reading material pass across their desks every day, probably several feet of reading, as opposed to a couple of inches of reading. You want some of your conclusions up front so that they can at least see if they are interested and then decide whether or not they want to go ahead and read how you got there. Then use pictures if you can. Use charts and graphs instead of tables. There are also some words to avoid: for example, crisis, at risk, empowerment, and comprehensive coordinated services; words that are so overused, have been used very loosely, and have lost the essence of what they really mean.

Now that we have talked about all the things that you cannot say and the limited space you have in which to say it, let us talk about what you ought to put in this precious space you have. The questions that policymakers ask us generally are: What works? For whom? How many people are going to be affected, and how much are they going to be affected? Does one alternative work better than another? Policy is essentially a matter of choices, and you need to give policymakers some advice on which is the better choice. Finally, how much it will cost to generate change. If we had more information about the return that you are likely to get with this alternative versus that alternative, we would be moving the field forward.

I have talked about the journal and implied that not every policymaker is likely to read 100 or 200 pages of a journal. What are some other approaches that we might use instead of a journal to get across the points that we want to make? One approach is policy briefings. The policy briefings are for legislative staff at the federal or state level, bringing together mid-career level practitioners, informing them about policy issues and trust, so that when they go home, they will report and use those findings to influence policy and practice. We have been talking about getting research into practice, but practitioners can be powerful messengers of research findings to help influence policy. Head Start has been remarkably successful in doing that.

Another important technique is the media. Carol Weiss, a researcher from Harvard, uses the term "knowledge creep." She says that research findings have their most powerful impact when they are so well-known by the relevant networks and the general public that they are accepted as truth. That is why we want to do media and press outreach activities. The early childhood community should be working for "knowledge creep," and see if we can achieve that.

I want to end with realistic expectations. Winston Churchill said, "It would be a great reform in politics if wisdom could be made to spread as easily and as rapidly as folly." We are trying to do that with some of the techniques that we have talked about, but it clearly is a difficult

Plenary III and Closing

process. Researcher Carol Weiss from Harvard has thought a lot about this and says that researchers often get frustrated because they do a great study and the results are clear; however, it disappears without a trace, with no policy change. She says that should not be such a surprise to us. Think about all of the things that have to happen before you can achieve a policy change. On the research side, you must have relevant research pertinent to the policy question. It has to be available before the policy decision is made. It has to present an intervention that is within feasible parameters. The results must be unambiguous, and that is difficult all by itself. The results have to be known to decision makers. They have to understand the findings. The results have to be consistent with entrenched interests, or they are going to run up against the political difficulties of getting change to happen. Findings have to suggest an intervention that is implementable within existing resources. That is just on the research side.

Now think about it from the decision maker's side. Decision-making is fragmented. In the early childhood field, there are different administering agencies at the local, state, and federal levels. There are different congressional committees overseeing different funding streams. Decision makers change jobs frequently. You might have developed a wonderful rapport with decision maker A, and then she takes another job or loses office. Decision makers may not wait for results. Jeffrey Stoddard was talking about Anita Zervigon-Hakes' article in which she talks about how decision makers sometimes need to implement a program because they have an election coming up. They are not going to wait for the research results. Research may suggest action beyond the agency's resources. The research findings may be beyond ideological and philosophical boundaries. They may suggest something that the policymaker is not willing to do. It is not what he or she thinks is the role of government or thinks ought to happen.

For all of these reasons, Carol Weiss suggests that it is not likely that you are going to get one great study that is going to lead to a specific policy decision. On the other hand, she says there are many uses of research. Sometimes it will be used to make a specific decision. Often it is going to be used to reinforce a commitment a policymaker already has made. Other uses are to persuade or neutralize critics; to bolster supporters who may be getting anxious about all the criticism; to shift responsibility from the policymaker's shoulders onto the broad shoulders of science; and to change the premises of policy debate. It is important to have realistic expectations as you think about the role of research in shaping policy. It is not likely that we are going to have one study that is going to change the world. However, it is possible to amass information, to transmit it carefully, and by doing this, to help move policy and practice forward on behalf of children and families.

Esther Kresh: There are many things that I will take away from this conference, but there is one special thing that I did want to share with you as part of this closing. The other night at the reception, I bumped into a wonderful practitioner by the name of Juanita Santana. Juanita shared with me her story about coming to this conference and how she felt about it. I asked if she would mind telling an audience exactly what she told me. I am going to ask Juanita to come forward now and share with you what she told me.

Juanita Santana: I came with definite questions in my mind about the potential for partnership between researchers and practitioners. I want to thank Dr. Stoddard for his presentation, because he was able to address some of those same issues that I shared earlier in one of my presentations. As a practitioner, the first question I always ask about research is, "How can I use the data that you are presenting? How can I use the information do a better job than I am doing in my

community?" In some instances the frustration is that it is interesting, but there is nothing I can do with it. After this conference, spending time in different symposiums and discussions, I have learned that we need to be working together. It was interesting to listen to Dr. Stoddard articulating the differences in the paradigms that we have. It was helpful for me to recognize that we have to see two areas. One is a narrow approach where the researchers are doing work in specific areas such as child development, health, mental health, or family interactions. The other is the broader aspect of research in the context of societal environments that impact the families and children with whom we work. There is a story about a village with a river alongside. There is a baby coming out of the river, and the people from the village run to rescue the baby. As time goes by, more children come down the river, and people from the village keep on rushing out to rescue the babies. It continues on. Soon the villagers have to start creating a plan because they want to make sure that as more babies come down the river, they do not miss any of them. One day, someone suggests that they send someone up stream to find out who is throwing the babies in the river in the first place.

This week has given me the time to think about all of the serious problems that we have. We practitioners have a sense of urgency. We need to work now in taking care of these problems. I recognize the tremendous need to be patient with each other, to educate each other, and to bring those paradigms together and share them so we can come back with a plan. There is an African saying that if you do not know where you are going, any path will take you there. After this conference, it is critical that we determine where we are going. I was in one of the sessions where questions were asked about where we are going and what long-term goals we want to accomplish together as practitioners and researchers. Until we do that, we are going to continue to have difficulty bringing our paradigms together. There has to be a more comprehensive approach with a definite line in the direction of where we are going, to be able to be successful.

Esther Kresh: Basically, our products are social services, and we usually do not think of social services as technology. However, when you think of the kinds of things we do as a technology, then it is easier to see the role of research, from basic research to applied research, which is the technology, and the people who put the human face on this with their wisdom, their experience, and their compassion. There is a place for all of us to work together. There are many things that we do better today than we have ever done before. Can we do better for children and families? Yes, we can. Are we doing better for children and families? We hope so. There is much to learn.

There is a goal that we keep talking about, and that is that every child should enter school ready to learn. We have come further than that goal. We understand today through research and the kinds of things we do that in order to ultimately reach that goal, we first have to put the goal in of bringing every child into the world ready to learn. Research has told us that; the experience of practitioners has told us that. We know now that regardless of what culture a child comes from, what language a child speaks, what country of origin he/she comes from, we can help those children succeed. We know how to do it without denigrating or trying to extinguish their culture along the way. There are many things we can learn, but as we go on there are many challenges. We have other rivers we have to go up. If we listen to each other, if we are patient with each other, we can certainly accomplish the goal. The reason that all of us are at this conference is to make a better life and a better world for our children and families.

Plenary III and Closing

Faith Lamb Parker: Esther thinks that she and Juanita have closed this conference, and we all know that she is wrong. We have a little something to add. First, we want to let Esther know how much we appreciate her dedication to pursuing quality Head Start research. We also want to let her know how much we love her. We put together a short ending of our own through a rigorous process of consensus building, collaboration, and partnership. We have agreed upon several words that we feel personify Esther. They are committed, courageous, and principled, with vision and stamina.

(At this time, several attendees who know Esther well told stories and poems to exemplify the words. The following are excerpts from those presentations.)

Deborah Phillips: Jim Heller, who had to take a plane at noon, can be blamed for this original poem that Daryl Greenfield is going to read.

Daryl Greenfield: We are talking about vision and stamina. What I would like all of you to do is to picture your favorite version of the Eveready bunny commercial, but I want you to picture Esther as the bunny. My favorite is the one that occurs in the Star Wars scenario with Darth Vader trying to get the bunny and not succeeding.

The title of this original poem to Esther Kresh is "An Ode That Won't Corrode."

*In most things of action,
You will often find a battery
To spark the tiny engine
And make it run accurately
A research conference
Is a thing of action
If you are going to make it work,
You had better find a diehard
Fortunately for all of us,
Our power source is steady
For twenty-five years in Head Start,
She has been ever ready.
So today we salute Esther Kresh
For her vision and her knowing,
Her resolve to hang on tight
As she keeps on going and going and going*

Merrily Beyreuther: I would like to pick up on a note that Olivia wrote the other day about Esther having given her life to Head Start. I have known Esther Kresh for many years. When I was in the regional office, I occasionally interacted with her, but in recent years, I have had the pleasure of working more closely with her. Esther certainly is that spark. She is that Eveready battery, and we commend her for that.

Ann Linehan: I am taking the place of Helen Taylor today. You know that our Associate Commissioner has not been feeling well. She was quite disappointed to miss the research confer-

ence, and when I spoke to her yesterday this was the event that she was the saddest about missing. I have only been in the Head Start Bureau for three months, and I thought that I knew most of what I was getting into when I joined the Bureau, but no one told me about Esther. Like the Olympic torch that has been around for how many hundreds of years, no matter how hard it rains, the fire does not go out. You cannot douse it. Esther, this has nothing to do with the color of your hair, but you are the most fiery woman I have ever met.

On behalf of the Administration for Children, Youth and Families, we have a plaque that we would like to present to Esther in a quite serious tone. *Esther Kresh, Ph.D., for your 25 years of dedication, creativity, ingenuity in keeping research at the Head Start Bureau alive and thriving. Presented by Helen Taylor, Associate Commissioner, Head Start Bureau. Presented at Head Start's 3rd National Research Conference, Washington, D.C., June 23rd, 1996.*

Symposia

■ Head Start Research: Informing Quality Practices and Policy Construction

"Conversation Hour" with Edward Zigler, Julius Richmond, Sheldon White

Julius Richmond: My colleagues and I have agreed that this should be your session and not our session. We would like to be responsive to enable you to be activists in this session. All three of us have been involved in Head Start since its inception. My two colleagues, in particular, have been deeply immersed in the research and evaluation dimensions of Head Start and concerned about the services it provides. They have been the analysts as well as the architects. I recall vividly in the early days how much time and effort Edward Zigler set aside to help us launch the Head Start research effort. Later, of course, he had the opportunity to direct the program for a number of years. My colleague, Sheldon White, has been the principal analytic figure in research for the duration of the program, but he also has been a friendly critic. He has been one of the major forces in helping the program evolve. He has just chaired the Head Start Roundtable at the National Academy of Sciences, which has been responsible for making some pointed suggestions about future directions for the program.

Question: I would like to hear more about the research Roundtable.

Sheldon White: The Head Start Roundtable met for about two years and held nine meetings. It was charged by ACYF to address two principal issues. One was thinking of ways in which the effects of Head Start on families could be studied and recorded. Two was to think about what new areas should be included in a new research agenda. We produced a report, called "Beyond The Blueprint," available from the National Research Council, in which we lay out research ideas in three principal areas: 1) how to deal with diversity in Head Start; 2) how to study Head Start program/community linkages; and 3) how to deal with economic changes affecting research on Head Start. The Roundtable did additional work that was not formally reported, but that was capacity building. We held several important sessions covering the following issues: 1) data archiving; 2) new kinds of research on children and families and how that research could be used to better understand what happens in Head Start centers; 3) interagency collaboration and how Head Start could benefit from tying into the research budgets of other agencies dealing with early childhood; and 4) field-initiated research.

Question: Did you have any Head Start parents on the Roundtable?

Sheldon White: No. We had three groups of people: academics, Washington administrators, and Head Start agency directors. In another iteration, it would be good to involve parents.

Comment: I am a former Head Start parent, and I have worked on some long-term and some short-term Head Start research grants at the University of Pennsylvania and at Temple University. I would find out who won a grant that year and then sell my expertise of collecting data in the field. There are advantages to having a nondegreed, well educated Head Start person doing this type of work. I am still an employee on several grants, but there is not enough mentoring going on. I moved from the welfare rolls eight years ago, and within one year I learned about data collection in courses I took as a job requirement. I started to learn the vocabulary, how to enter data, looking at data sets, and learning how to read them.

Head Start Partnerships, Research, Practice, and Policy

Sheldon White: Our hope is that we can cease the solely top-down initiation of research and spread it around so that all parties with an interest in Head Start can see the things they care about studied and worked on through research. Parents should be part of that process.

Edward Zigler: It is fair to say that there has been no program in the entire history of the United States that has involved parents more fully than Head Start. I was the federal official that created the policy councils that have veto power at the highest level, and at least half of the members on those councils must be parents. Another example is the Transition Project, one of my godchildren, a good example of how research in Head Start should be done. The Transition Project is designed to follow children in 31 sites for their first four years of public school and to continue parental involvement and all of the services that originally came with Head Start. Some measures were developed with the help of parents, because they objected to certain measures that they felt fed into stereotypes. You generally do not see that type of sensitivity in research because usually the "experts" develop the measures. In this case, the measures the parents objected to were eliminated. To get the cooperation of parents, they must be involved early in the life of a project. We could do better, but I do not want to leave you with the impression that our track record is awful. Compared to everyone else, it is pretty good.

Question: My name is Kay Mills. I am working on a book about Head Start. You mentioned that the panel had worked on ways that Head Start's impact on families could be measured. Could you tell us more about that?

Julius Richmond: In the past 5 or 10 years there has been extensive research on family systems and dynamics, which puts us in a better position to talk about families who are doing well and those who are not doing as well. We are trying to move from being obsessed with I.Q. points and cognitive development to a position where we can look in a three-dimensional way at a Head Start program. If we get away from formal research and talk to parents who were in Head Start, we hear some wonderful stories. These stories tell us something must be happening, at least for that person. As a group, we have been trying to gather the best ideas about how to study effects on families so that we can document what is really going on in Head Start centers. We have recommendations that are in the report.

Question: I am Art Frankel from NYU School of Social Work, NYC. I have been collecting data on social work involvement in Head Start over the past 30 years, both at the policy and practice levels. Social work has been doing many of the things that Head Start does in terms of community involvement, the generic approach to practice, and now the Family Service Center movement, which is basically case management. How is it that social work as a profession is so poorly represented in the Family Service Centers? Why do you think it has been this way over the past 30 years?

Julius Richmond: Let me say, but not defensively, it was not for lack of trying. I can recall vividly several national meetings called within the first few months of Head Start that tried to involve all of the child care disciplines, social work among them. We also tried to involve all the mental health disciplines, and I would certainly include social work in that. The rhetoric was always good, but we never seemed to be able to follow through well enough. It may be that social workers were well situated in their own institutional frameworks. Other mental health profession-

Head Start Partnerships, Research, Practice, and Policy

als had the same problem. The people from child development, early childhood education, and pediatrics seemed to be more prepared to engage in comprehensive community-based programs.

Edward Zigler: It is something that we do need to address. We may have erred in this sense: when we established Head Start programs in 2,700 communities across the country within a six-month period, it became difficult to draw people away from their institutional arrangements. We may never have recovered from that.

Sheldon White: One of the problems is that social work is spread into so many different areas that there are few people in child care, although there are an enormous number in child welfare. Social work schools are not uniform like early childhood education, where there is a concentration in one area. There has not been an institutional focus that would allow social workers to be easily integrated into Head Start. In the Family Service Center project, even when there was money to hire master's level social workers, and the task force in Washington suggested that Family Service Center workers "follow the best practice of social work," they did not hire social workers. There seems to be some resistance in Head Start at the local levels. In the same way, there is a resistance from social work schools to place interns in Head Start. Part of it may be our bending over backwards not to create rivalries with other agencies in communities or to duplicate services. The point that you are making now is that we should have had more social work presence in Head Start to make those linkages to social agencies in the community.

Comment: I am Saburah Abdul-Kabir from the University of Pennsylvania. My comment is about Head Start being inclusive of parents, all the way from the decision-making process to volunteering in the classroom. I went that route through Head Start and I applaud their Parent Involvement Component. However, when I come to functions like this and we talk about community partnership, I see fewer parents, or none at all. I may see practitioners and nurses, but not grass-roots people who have worked their way through Head Start, maybe gone back to school for social work or early childhood development. These people are not utilized on a level where they could help with policy changes that will filter down to the local levels of Head Start. Of the 6,300 families in the Philadelphia Service Center, I am the only parent that has been hired on research grants. I taught myself the language of research, but I do not have a Ph.D. I have six children who went through Head Start. I would like to see us included more on a national level because I think Head Start is a grass-roots organization.

Julius Richmond: I would like to make one more comment about the grass-roots nature of Head Start. It happens I am interested in the history of developmental psychology, and I spend a lot of time reading about settlement houses such as Toynbee Hall, Hull House, and the other settlement houses that started in this country at the turn of the century. One thing that is clear is that there is a sharp division between the child development researchers and the social service workers. It is a division between the Children's Bureau (child welfare) and those in academia. This is not a new thing invented at the time of Head Start. I do not know enough about the social dynamics in the 1960s when Head Start was conceived, but I think there has been a separation that has, to some extent, been harmful to developmental psychology and probably to the field of social work as well.

Head Start Partnerships, Research, Practice, and Policy

Comment: I am Ann O'Keefe, currently of Centerville, VA, and a former Head Start employee. I have been concerned about references to early research and evaluation as if in the early years research centered on the Stanford-Binet, WISC, and other intelligence tests. Aside from the Westinghouse study, I am not aware of that. I have been involved in Head Start since 1965. From 1971 through 1978, I was in the ACYF office and was involved with the evaluation of research for two of Dr. Zigler's programs: Home Start and Child and Family Resource Program. All of the evaluations at that time were based on the most current thinking and were comprehensive. No I.Q. tests were ever given. I remember the phrase "social competence" as one that people were struggling with. My recollection is that from at least the early-70s on, the struggles and the attempts were to look at the comprehensive nature of Head Start. I remember well how Head Start raised people's consciousness about children's health, and at that time was recognized as the largest health program for low-income children and their families in the country. My point is that if in 1996 we can look back with our eyes closed about early research, what precautions are you taking so that future research will not be faced with the same problem in 10 or 20 years?

Sheldon White: Steven Leacock, the Canadian humorist, once said a half-truth is like a half-brick. It carries further. One of the things that we are trying to deal with is the legend that Head Start is an I.Q.-modification program, or if not an I.Q.-modification program, then a cognitive development program exclusively. While everyone sitting here knows a lot about Head Start and understands that it is a comprehensive program, I can tell you that in university life, even very sophisticated people have surprisingly limited ideas about what Head Start is and what it does. There are people who believe that Head Start was killed by Jensen. However, that is only half the answer. Let me give the other half. I have to stand before you as one of the people who helped design the Westinghouse evaluation, so I have a lot to live down. However, during the design of the Westinghouse evaluation, every effort was made to come up with so-called noncognitive measures. In fact, I have been on a lot of evaluation design teams, and I have never been on one that did not make some effort to look at social, affective, and other factors. If the group did not do it spontaneously, Barbara Beiber would show up and tell us to get cracking on that. We had no theory then. We did not understand what social or emotional development meant. The trail is littered with improvised attempts to deal with noncognitive factors, and they were not noticed or remembered in the discussion of the study because nobody understood what the measures were. Nobody knew what to believe about those measures. Whether we understand I.Q. or not, people thought they knew what an I.Q. test meant. Whether we understand school achievement or not—and there are a lot of questions about what school achievement tests test—people think they know what it means. The problem we have had over the years has been in trying to develop a better understanding of what social development and emotional development means in children and then to try to reflect that understanding in our indicators. I believe we will never go back to that early period because we now have some sophistication, and understand a little better how to look for noncognitive factors. And when we get indicators, we know what they mean.

Edward Zigler: What I tried to do in Head Start was to insist that we say that everyday, social competence is the goal of Head Start, not I.Q., and social competence is related to cognitive ability. However, theories change; they come and go. In the mid-60s, one of the most popular books was Joe Hunt's *Intelligence and Experience*. Joe was trying to swing the pendulum away from Gesell and maturationism, and he came up with what I could only call a very naive environmen-

Head Start Partnerships, Research, Practice, and Policy

talism. Joe was convinced after reading Piaget that we could increase I.Q.s by 70 points, and published papers that showed 70-point I.Q. increases. This gave us the idea that you could take a small experiential intervention and have huge cognitive changes in the child. The second was Ben Bloom, who said, "Half the learning of the child is over by the age of four." That was nonsense when he said it; it is nonsense today. We do not know when all learning is over, so how would you know when half of it is over? I wrote a paper in the *American Psychologist* called "I.Q. Versus Social Competence in the Assessment of Early Intervention Programs." Some of us were looking at social motivational factors. I wrote early papers saying change would occur in the child's social motivational system, which is more plastic than formal intelligence. The Centers for Disease Control is doing a project called Project Begin. They are going to use the Abecedarian model all over this country, and their goal is going to be I.Q. changes. As a public agency, they think that it is a vehicle for cutting down mental retardation. It is a long, complicated struggle. It is not over; it is going to be fought continuously. We are all interactionists. Nobody here is talking nature or nurture. We all know that cognitive development is itself a product of experience as well as genes. However, it has been a long, hard, continuous struggle.

The Westinghouse report was close to being a disaster for this country. It was followed immediately by the Jensen report, which was one more evaluation of the nature versus nurture issue. The first sentence of the report in 1969 was "Compensatory education has been tried, and it has failed," all on the basis of I.Q. scores. What Shep will not say to you is that he showed his wisdom. He would not go along and refused to sign off on the report. He saw the shortcomings of the Westinghouse report before anybody else did and refused to put his own imprimatur on it. It took courage; it took wisdom. I would like to commend him for it.

Comment: I can recall having written a paper that was somewhat of a rebuttal to the Westinghouse report. In it I quote from the Butterfield and Zigler article that focused, even back then, on motivation rather than on I.Q. They raised the question, "Is it not more important to know what motivates children to learn than to be measuring I.Q.?" The problem was that most of the psychologists who were doing testing knew how to do I.Q.s, but, as has become abundantly clear, they did not know how to measure social competence. Therefore, there had to be a maturation of the field, and it is still evolving. We still do not have the kinds of measures that do this as well as we would like, and particularly those that over the period of childhood would give us the data that we would like.

Question: I am Harriet Romo, a sociologist who will be in the School of Education at U.T., Austin. I am concerned about what other kinds of indicators you are looking at, like ethnography. Head Start should be commended for looking at the complexity of students' experiences and the context (family and community) that they grow up in. However, some of the measures that keep coming up do not capture the essence of what is going on. Even in family systems theory, models of dysfunctional families and functional families are being used. When I am out in the field, I see these families and the wonderful things that they are able to do, the richness in their lives. These measures are inadequate to accurately reflect that. In addition, there are indicators like the HOME inventory that are middle class and White. In the Family Service Center project that I was evaluating, we had a literacy test that used questions based on job applications and check writing. I am working with rural Mexican immigrant families who have complex ways of dealing with money and complex ways of getting jobs—not by filling out job applications and not by using checking

Head Start Partnerships, Research, Practice, and Policy

accounts. I want to know what is happening in measurement that includes ethnography, and how are you measuring the subtle, rich experiences of families?

Sheldon White: In measurement, we are beginning to throw away the word "measurement." The view that regards programs as adding and subtracting commodities, adding I.Q. and taking away maladjustment or something like that, is giving way to a dynamic developmental view of people. It is a view of people who are moving through time, solving problems as they go. There has been a lot of emphasis on qualitative research methods, which includes ethnography. The best material that is coming forth now is more complex than the traditional measurement methodology. It would be foolish to sit here and say that everyone now believes that we ought to use qualitative research methods, but there is a growing consensus that, particularly when it comes to social programs and interventions such as Head Start, we need more of those types of data.

Comment: This goes back to what Ed Zigler and I were saying earlier, that this is where parent involvement and community-based people are needed. First assess a community, then develop the research from the bottom up. You would not use certain measures in certain communities; for example, an urban, inner-city child versus an Appalachian child. This goes back to how Head Start involves the parents and why we need to have that input on all levels. They would already be designed with the people as part of it. That also makes the community feel invested in it, and produces more honesty and better relationships and partnerships.

Question: My name is Roy Peterson. I am from Flint, MI, and am neither a Head Start person nor a researcher. I have been a partner with Head Start since it opened, providing health care services. My question is: If the research were done adequately and clearly, would the results of the research over the years be so compelling as to have turned the political corner in terms of dollars and expansion? The question is a research one, but it also is one of communication and leadership. Is it that the information and the results were there, but not communicated? Or is it a question of strategy? What would you do differently? Based on that, what should we be doing for the future?

Julius Richmond: I can respond to your question best by offering a conceptual model of how we shape policy in an open society like ours. I view it as the interaction of three factors: 1) the knowledge base; 2) the political will by which we generate resources (from either the public or the private sector); and 3) some kind of balance or tension. These interactive factors also need to be accompanied by a sound social strategy. Our knowledge base is solid, but it has not always given the public perception of being solid. The professional community shares a great responsibility for this, because we have aired with the public our research differences much more than we have shared what is positive about early child development. Our message is often ambivalent. In the mid-60s, we had the political will to put over 500,000 children into Head Start in one summer, with great enthusiasm and excitement. That has eroded and we, as citizens, have the responsibility to rebuild that political will. We need to be clearer with our message as social strategists when we go to the decision makers in either the public or the private sector. The needs of children and families, and particularly those who are living in adversity, are extremely complex and multifactorial. It is not all health, all early childhood education, or all social services, but a combination of all of these things. Based on the experience that some of us had had building other early intervention programs, we were able to demonstrate that Head Start needed to be packaged

Head Start Partnerships, Research, Practice, and Policy

as a comprehensive program. As an example, the movement to an Early Head Start program indicates the growing national recognition of the importance of the early years, but also our growing effectiveness in saying we know how to put together a comprehensive package that will be effective.

Edward Zigler: I have asked the same question of myself many times. Health in Head Start has always been taken for granted, but we get no Brownie points for probably what is the most cost-effective component in our effort. I was asked by the Public Health Association to review all of the Head Start research on health, which I did in a recent issue of the *Annual Review of Public Health*. It is an impressive record, but we have not told the story. Had we shown what could be done with this kind of expenditure, we could have used that evidence to bolster the will to help us with Medicaid to do other things. When I argued the social competence criteria for Head Start, the first one that I listed was health. Psychologists who have the primary responsibility for evaluation of Head Start and Head Start-like programs do not even look at health. Pediatricians should have been more involved in the health evaluations. Developmentalists should stop raising the artificial barrier of health indicators and nonhealth indicators. We have failed for 30 years to get our success in health out. If anyone did an honest cost-benefit analysis of Head Start, the program would totally pay for itself with the Health Component alone. Even the harshest critics of Head Start usually acknowledge that the Health Component of Head Start is worthwhile. Your question is an important one, and something that all Head Start people are going to have to think about. We need to turn that around, as I have been trying to do for 30 years unsuccessfully.

Sheldon White: We are trying our best to create a multidimensional research program in which a variety of Head Start effects are recognized. By creating such a program and making it known, we will start telling people that there is more to Head Start than I.Q. points. The reality of the research on Head Start now shows many Head Start effects. My job is to try to figure out how to develop a diversified research program.

Question: My name is Sue Rasher. I am the Illinois local evaluator on one of the transition projects. We have collected data from kindergarten through third grade. It is an array of child, family, school, and community data. We are at the end of our data collection for the first cohort. Is there value in continuing to follow these children and families? If you were going to, what would you continue to follow?

Sheldon White: Yes, there is value. What I would follow is simple face-value indicators of the success of the child in life. One of the reasons we get tied into knots is because the psychometric instruments are complicated and have properties that we do not understand. However, after the period that you have been following, there comes a time when children do or do not drop out of school, and when things like delinquency begin to show up. There is every reason in the world for you to track those children, if there is the money in the State of Illinois to do that.

Question: My name is Angela Wilson-Quayle from George Mason University. I am a developmentalist interested in the interface between cognitive and social/emotional development in Latino children. An implicit assumption of the Head Start program is that we are there to give children sufficient help to integrate into the school system, and with that extra help, to be able to fare reasonably well throughout their subsequent student career. If that has been a basic principle,

Head Start Partnerships, Research, Practice, and Policy

then we have largely failed. I say that at the risk of being unpopular in this room. However, it seems to me that if we have set out to improve children's cognitive functioning, which I believe was an essential first principle, then we have not really done that. From what I have read, it seems to me that the cognitive gains as a result of participating in Head Start have been rather short lived. They have endured perhaps for a couple of years. The gains that we have seen have been more in terms of social competence. Looking at older children who have gone through the program, we see less teen pregnancy, less delinquency, and other things of that nature. If the program is to be what it essentially set out to be, and be more than a mechanism for increasing social competence, should we think more about middle-school children and older children? If so, what does that do to the face of the educational system?

Edward Zigler: I refer you to a book I just put together called *Head Start and Beyond*. The idea that these children are going to do well in school if they go to absolutely awful schools, as new data have shown us to be the case, is ridiculous. You have to take a developmental perspective. If you want to impact school achievement, you need a good school. I recommend Michael Rudder's book *Fifteen Thousand Hours*. That is the time a child is in school, from kindergarten until graduation. He finds that the variation in the quality of schooling makes a difference in how well a child does in school. Early theorists, like Jim Coleman in the 60s, gave us an inoculation model. We need to give the message that there is no "silver bullet" for the age of four. There has to be a good environment throughout the early years, birth to 10 or even older. At a recent conference I attended on the brain, it was said that the period of plasticity is from birth to 10 and in utero. We have to think in those terms. In this country we want to get off cheap; we look for magic bullets. If there is a good treatment, people always want to find a way to deliver it in a less costly way. However, the facts are that good-quality programs cost more than bad-quality programs; long-term intervention costs more than short-term intervention. We keep trying to finesse those facts instead of talking honestly about human development to decision makers in Congress and the executive branch. It is very difficult to change the growth trajectory of a child born into poverty. I think we can do it, but it is expensive and it is hard, and most people do not want to hear this.

Sheldon White: Since the beginning of Head Start, there have been efforts to project into the public schools what Head Start was doing. When Head Start programs were created, the hope was that some public schools would take sponsorship. In sponsoring Head Start centers, they would absorb the kinds of accommodations needed to be made for poor children. Along the way, Follow-Through was created, but it was not successful as a program. The goal was to try to create elementary school environments that would "follow through" on what Head Start was doing. Now we have the 31 Transition projects. This is another effort to try to build bridges between the elementary schools and Head Start. At this moment there are 28 states that have said that they are going to create Head Start-like programs within their school systems. The problem is that in the states where they have been implemented, they have not been comprehensive programs. Therefore, it is not clear to me that states that simply declare their willingness will achieve as comprehensive a program as Head Start. My own personal hope is that in time there will be a movement from Head Start into the public schools of a need to go beyond didacticism to developing curricula for children in a multicultural community.

Head Start Partnerships, Research, Practice, and Policy

Julius Richmond: Follow-Through was intended to do what Shep was suggesting, but history was against us. Vietnam came along and many social programs could not expand at that time. As a result, the program did not get off the ground. In the current context, we have to remember that a lot of things have happened to our school systems, and yet the schools are there. Ultimately we need to tie what goes on in the preschool years—not just the year before but all of the preschool years—to the school reform movement and hope each can influence the other, that they ultimately could be tied together. However, schools are large, bureaucratic institutions, so it is not an easy thing to do.

Question: My name is Richard Gonzales. I am the Head Start director for the New York City grantee. In looking at the program and what has been taking place, it seems that people often do not know what Head Start is. We, as a Head Start community, often do not feel confident enough to approach people or feel that they will think it is important enough to get involved. Many times the work falls on the shoulders of one or two people because the rest of the staff or parents may not feel confident enough to approach people. What we have begun to do in some of our programs is to look at basic issues. What we have found is that when you put out an invitation to a group, nobody responds, but when you go to an individual and ask him/her to help, they readily agree. For example, we have begun going to schools of social work and talking to students and asking them to do internships in our programs. As a result, we have recently had larger numbers of social work interns come into the program. As they come in, the comments that we hear all the time are, "I did not know this about the program," or "We did not know this was taking place." We need to continue to expose people to more knowledge about the program and not believe that they already know what it is about. Hopefully then we can begin to create motivation.

I am also concerned that we view research as someone else's responsibility. Programs do not know much about research. Maybe individuals do, but certainly staff, parents, and many of the programs know it is important but do not necessarily have the skills to get involved. Those few who have the concerns and complaints report that researchers come in and many times know nothing about the Head Start program and try to do research in an inappropriate way. At the same time, Head Start staff do not know enough about research to help the researchers do a more effective job, or to then utilize the information. When research comes out, sometimes people do not know how to make use of it, either because of the way that it is written or because they feel that someone else has to do something with it. I tie all that together to ask a question: How do we begin to more effectively take advantage of the messages that you have given us today, and that we are learning ourselves, to learn more about research and to help researchers learn more about Head Start so that we can make good choices? How do we help staff, parents, and others feel more confident about getting involved?

Sheldon White: The single dominant theme in our discussions at the Roundtable was the need to take active steps to bring researchers and practitioners together. Exactly the kinds of remarks you made were expressed there. That is, that researchers often do not understand the Head Start centers that they are trying to deal with, and Head Start people cannot make any sense out of the research that is supposedly for their benefit. There is a need now to take two communities that have existed apart from one another—and they are not always friendly towards one another—and try to build bridges between them. We came up with a half a dozen different ideas about ways to start. Head Start has been active in the past five years trying to build what it calls

Head Start Partnerships, Research, Practice, and Policy

University Research Partnerships. There are a number of projects now that require a Head Start center and a university to apply together. There are other efforts underway within ACYF to try to build the bridges that we all recognize have to be built between the two communities.

Julius Richmond: Coming out of the field of medicine and thinking of analogies or analogues, Head Start research is analogous to what in medicine we think of as clinical investigation. What differentiates a clinician doing research in a biochemical field, to take one example, from the biochemist who is sitting in his laboratory and never sees any patients? The difference is that the clinician finds his problem in the clinic. His research is stimulated by a human problem. In these university linkages, people who have the methodologic competence and the theoretical background team up with the people who have the practical problems but do not immediately have the methodologic competence to solve them. Before Head Start came along, it was not that we had no child development researchers. Obviously we did and there was a rich literature. However, little of it related to poor children and their families because that was not where the researchers were. They were on university campuses. One important ingredient is that the problem that is to be investigated should—and I do not mean this in a simplistic way—have some relevance to Head Start and to the children and families who are in the Head Start programs.

Comment: My name is Ayman El-Mohandes, and I direct the Newborn Child Health Division at George Washington University. I am also a pediatrician. I was challenged by Professor Zigler's comments when he talked about health outcomes. Retrospectively, you may have blown it, but prospectively, there is a great deal of information that can be useful at the policy level. The kind of information that could have been useful, but unfortunately was not forthcoming, was related to specific health outcomes such as immunization, growth, and nutritional parameters. Unfortunately, in the current environment, where most of the traditionally underserved populations are being delegated to managed care, the importance of such information is not a priority any longer. I would like for you to comment on that because I propose to put some time and effort into this, since there seems to be a need to understand these issues in relation to long-term outcomes. Issues such as teenage pregnancy, substance abuse, injuries, and violence cannot be immediately captured, but must be followed over time prospectively. Immediate outcomes that we could look at relate to parental health beliefs and behaviors, and family patterns for utilization of health care. I would like to know whether emergency room utilization, utilization of preventive health care, and the patterns of utilizing health care for sick children and infants are foci in the Head Start intervention. These are of a different nature as outcomes, not to be immediately compared to immunization rates. However, they would be relevant to policymakers and to the understanding of the impact of this intervention on family health. I disagree with Professor Zigler that this is easy to do. Retrospectively, it would be easy perhaps to tease out the cost-effectiveness, but with a change in the health care delivery system, it will need to be done prospectively, with a little bit of insightfulness and with the collaboration of people who are health economists as well. I believe that could be an interesting focus. What do all of you think about that?

Edward Zigler: We ought to do exactly what you are suggesting. We have not done enough because it has not been enough of a focus. I once wrote a piece called "The Future of Early Childhood Intervention" in which I recommended that nobody ever mounted an intervention without doing a cost-benefit analysis, because what moves Washington and state capitals is a

Head Start Partnerships, Research, Practice, and Policy

clear demonstration that you invest a dollar and you get five dollars back. A good example is the WIC program. Kottelchuk did that wonderful research on WIC to show what you buy when you institute that program.

Julius Richmond: You have mentioned issues that are great problems in the health sector; for example, the delivery of health services. When Head Start began, we took the initiative to say that services for young children in poverty were so fragmented that we needed to bring them together in a comprehensive way. On the other hand, if one expends Head Start funds for all health care, then funds are not available for other things. Therefore, it becomes a difficult social and economic dynamic. If health care for young children is to be given in Head Start, how does one reclaim the funding from health funding sources? Usually that is Medicaid. That is not an easy thing to do, but Head Start programs have learned to do that, and it has become better over time. To again illustrate how complicated your question is, one could take the point of view that health services for a family ought to all be rendered in the same place so that the same practitioner knows about all of the health problems of the family, the parents and siblings, as well as the child(ren) in Head Start. Then we are dealing with a tension between systems. Since we are a pluralistic country, individual communities are going to find different ways of integrating these services in more effective ways. The renewed pressure for managed care is just going to make that more complicated. These are issues that need to be studied so that one can look across communities and see which seem to be arriving at optimal solutions.

Ayman El-Mohandes: We are interested in pursuing this line of research. We are doing something similar, looking at health care utilization patterns of high-risk populations with non-health care interventions. If any of you are interested in pursuing this, perhaps to enrich us, please feel free to contact me.

Question: My name is Robin Harris. I am with the Children's Defense Fund, Ohio. In the state of Ohio, we pride ourselves in providing the most state funding in support of Head Start, and we say that we serve 70% of eligible children. However, during the last budget, the legislature, which changed in its political make-up, wanted to know what they are getting for their money. They are focusing more on the fade-out issue than the benefits of Head Start. It is clear that even in the Head Start community, different people talk about it in different ways—about whether or not it is an educational, social services, or comprehensive program. The legislature is obviously approaching it as an educational program, and they have a research team to look at this. Although they are talking to a lot of people in the Head Start community (i.e., parents, a grantee, delegate agency directors and coordinators), they have no one on the research team from Head Start. Ohio is concerned about putting more money into Head Start, as the Governor wants to serve 100% of eligible children. The researchers already have realized that it is a developmental process; the target is not just three and four year olds. One has to look at children in kindergarten, in first through third grade, maybe even beyond. They are going to look at the cost of it, and it is going to scare them half to death. Some of the researchers are from Ohio State University, but they hired independent contractors who are not necessarily working directly with the university. They have two years to come up with a report.

Sheldon White: The problem is that people are saying that there is fade-out, and therefore, they are buying a product that vanishes before their eyes. It is important within the two years you

Head Start Partnerships, Research, Practice, and Policy

have to try to look at health benefits and the short-term educational benefits, and to document those well. There is absolutely no ambiguity about it: there are short-term effects. I think fade-out is a complicated idea that has been thrown around too simplistically. You have to do as much as you can with face-valid measures, and it does not have to take a Ph.D. to understand what the measure means. There is reason to believe that if you look at the families, the younger siblings of Head Start children, you will begin to start picking up the effects of Head Start. We have data to support that. You should concentrate on simple face-valid measures showing immediate effects of Head Start, or near-term effects of Head Start, not just in terms of cognitive development, but in terms of health and the family. It has to be addressed and thought about as a comprehensive program.

Edward Zigler: What you are describing is nothing new. It is called accountability. Why should any of us be surprised if somebody that puts up the money asks what they are getting for it? We have to be responsive; however, we may not be looking in the right places. If we are having sibling effects, right away the program becomes more cost-effective, and there is some evidence that we do. Demonstrating cost-effectiveness came up at the Roundtable, and it is certainly a part of my own thinking. There are now three major reviews of early intervention: 1) Fearington in England; 2) Yoshikawa, which was in the "Future of Children" article; and 3) a piece I did in the *American Psychologist* some years ago, entitled "Early Childhood Intervention: A Promising Preventative To Delinquency." This country is spending billions of dollars on prisons. The cost of the criminal justice system in America is overwhelming us. I have had state legislators from around the country tell me that if we could show something that they could put money into other than building prisons they would do it. We have some wonderful measurement; the delinquency/criminality literature is very clear. A small coterie of individuals cost this country a great deal of money because they become criminals. The other thing we know is that criminality starts young. We have some good measures that show precursors to later delinquency and criminality. You do not have to wait for someone to become delinquent; you could pick these children up at age six. If we could demonstrate that Head Start cuts down delinquency, there are big bucks there. In the High/Scope 27-year evaluation, where for every dollar spent you get a seven dollar payoff, the fact is that six of that seven dollars is in less cost to the juvenile justice and criminal system. That is a far cry from looking at I.Q.s and cognitive development!

Julius Richmond: Be sure that any short-term researchers who have not come out of the field have lots of opportunity to talk to parents. They are the ones who really know what the program is doing. They know it, they feel it, and they can be the most articulate people to express what new researchers ought to be looking at.

Robin Harris: The appeal to juvenile justice will work much better than trying to help poor children as an argument. That is a politically savvy argument.

Question: I am Lois Sexton, a Head Start director in North Carolina. I come from a state where tobacco research has produced some interesting results. It seems that we have other information that could help us move from research to practice. There is marketing and public perception that we need to address. The milk ads with the milk on the upper lip. We have a product that is wonderful; it is something that most people in this country prize. I believe that there still is a heart for young children. How do we market and package that? Do we go to a Dreamworks, a

Head Start Partnerships, Research, Practice, and Policy

Spielberg, or a Disney? How do we create the kind of next step beyond research to practice, to marketing?"

Edward Zigler: It is not complicated. We have just been reluctant. The fact is, the newspapers in your community have to come out every day. Head Start stories are wonderful stories. We have to get better at marketing than we have been. How many Head Start directors spend any time forming a relationship with the media person in their neighborhood and inviting them in? What has been missing is that we have failed to put a human face on Head Start, especially people who talk in statistics and jargon. I testify all the time on the Hill. The most powerful testimony is not delivered by scholars, but by a person who has experienced Head Start, and for whom Head Start has turned their lives around. One could do that locally with stories where the name is anonymous. Unless we get our story out in a positive way, and it is comprehensible, we are not going to be developing the kind of allies in the community that we would like to have. Some of this is actually being done at the Brain Institute. They twisted Rob Reiner's arm, and he is going to do a big TV special that points out the importance of the early years. Getting documentaries, getting books written, using our local media people to tell our story is all worthwhile. We have to compete with all kinds of other concerns and agendas. Whether we win or lose does not depend on what research we do, but on whether that research is convincing to people and whether the Head Start story is a convincing one.

Sheldon White: A wonderful report has come out of ACF: a beautiful statistical compilation of where children stand in this country. Some of us have been looking for that for a long time. The hope is that now it will be issued every year. We need to make clearer to people where children stand, which way things are moving, and what we need to do. We need a richer knowledge base in order to deal with the issues we have to contend with.

Julius Richmond: In terms of where children are generally in our society, it is unfortunate that we have to observe that things have gotten worse in recent decades, not better, in terms of total numbers of children living in poverty. We have been swimming upstream because we are trying to develop services for what is a larger and more diverse, and in many ways, a more disadvantaged group. In terms of the media, one needs to be in a position to suggest to people what they can do. Presenting them with the problem is not enough. One has to have some suggestions in terms of the action component that we want people in local communities to address.

Comment: I think there has to be a selling job. I do not think the facts and figures, the data that you are producing, the practice that we are doing, the conviction that everybody in this room holds that there are important things happening is enough. There seems to be the need for another step. Perhaps you could arrange a subsequent conference that could be not just research and practitioners, but research, practitioners, and marketers.

Julius Richmond: Some of the foundations have such an effort underway.

Comment/Question: My name is Brian Nelson from Minneapolis, MN. I work with a Head Start. My comment is about managed care. In Minnesota, we have been able as a Head Start to sign contracts with managed care associations. It has taken about three or four years to do it, but we are the best health screeners of young children in the nation. Do you have some kind of infor-

Head Start Partnerships, Research, Practice, and Policy

mation, a summary of what we can give researchers when they come into our program, about criteria that we expect them to follow. We started generating some of that, but I was wondering if you have something like that?

Julius Richmond: In some Head Start programs across the country there probably are some guidelines or protocols of this kind. If there are not, it seems to me the ethical guidelines of something like SRCD could be adapted for this purpose. I think that there are guidelines that have been developed in other contexts that could be readily adapted for these purposes. It is a good suggestion.

Question: My name is Ann Door. I am a Head Start director in Williamsburg, PA. I was interested in the health discussion because it has been useful to me to think about it in terms of the Revised Performance Standards, which link health with child development. Would you share with us how you feel those revisions will affect the view of Head Start as a national program?

Julius Richmond: The Performance Standards are intended to improve the quality of programs. They are called Performance Standards because there is a lot of flexibility built in.

Comment: I am Joanne Williams from Russellville, AR. I wanted to share with you that we spent a number of years in Arkansas helping to educate our current President and his wife about the importance of children and families. They have helped us in many ways to get new buildings through the Arkansas Industrial Development Commission. We have been a part of all the major research projects through the years, including Home Start and now Early Head Start. Arkansas is not a wealthy state. One thing we learned through the years is to use every resource. It troubles me that there have been times in recent years when Head Start programs have had insufficient funds to hire social workers, mental health specialists, medical people, and the experts needed to develop the comprehensive approach. If you come from a poor state, you shake every bush and you rattle every bone. My last comment is that the quality goes back to governance. The Policy Council Chairperson has a position on the board, and you utilize everyone around you, including your Governor and his wife, and your President and his wife. It all goes back to values, mission, vision, fiscal soundness, and, certainly, to governance.

Julius Richmond: Thank you for involving President and Mrs. Clinton in your programs. It reminds me of Confucius' old comment to the effect, "Tell me and I will forget, show me and I will remember, involve me and I will understand." What you did with President and Mrs. Clinton was involve them because we see that they do understand.

■ The Reality of Partnerships

"Conversation Hour" with Willie James Epps, Sarah Greene, Ron Herndon, Lonnie Sherrod, Hiram Fitzgerald, Robert Brown, Stephen Williams, Mark H. Schauer, L. Annette Abrams, Mary Fulbright, Wanda Smith, L. Mike Rice

Willie Epps: This is a "Conversation Hour," so the floor is open for questions and comments. I heard several comments regarding the two presentations that were presented earlier. Many of you remarked how impressed you were, and that you had a lot of questions about how these relationships got started.

Question: This is directed to the group from Texas. In the presentation that you gave this morning, you talked about the Margaret Cone Head Start. Are you running any other centers that you have for comparison with the Cone Center?

Response: We have just finished looking at the performance of some of the Cone Head Start children in the Dallas independent school district versus other Head Start children in Dallas. The Cone Head Start children are generally performing better. We want to be able to look at the performance of Head Start children from all the other centers in the Dallas independent school district as they go through kindergarten, first grade, and second grade, as well as the rest of the children who did not have a Head Start advantage.

Question: I would like to ask both groups to tell us about your plans for publishing, particularly about the results of the evaluation. I want my state to know about this.

Response: We already have a variety of materials available that describe the Applied Developmental Science initiative. It is broader than just the two partnerships that we presented here. We have a graduate program that should be approved by 1997, an interdisciplinary program that links 30 departments (i.e., disciplines) on campus and about 80 faculty members to a training program that will have a heavy emphasis on evaluation, design, and methodology. We also have a description of a training program that we are developing with United Way of Michigan that will end up with self-paced modules focusing on evaluation, design, and methodology. We published an article in the *Journal of Adolescence*. One of our agendas is to map out a publication schedule. In addition, we have brochures that describe what we are doing.

Response: We are at the point with each project of issuing a press packet to the media that is easy to understand and that talks about the partnership, the players, and the products to date. We want to begin to raise people's understanding of the issues, particularly local people's understanding. Our Vice-Provost for Outreach has asked us to put together standards of practice for all outreach programs on campus that draw from many of the transparencies you saw. These are basic elements to keep in mind as you work with communities, agencies, and systems off campus.

Response: We have been working with researchers at MSU in community and ecological psychology. MSU researchers have served as consultants and third-party observers on our process. Some of their observations on the functionality and dysfunctionality of our process are very instructive to me and our group, and will also provide useful information for journal articles.

Head Start Partnerships, Research, Practice, and Policy

Response: We do not have any scholarly journal articles written yet. We do have information booklets that give some of the history of Cone Head Start Center and the program with some of the findings.

Question: I was interested in why Texas Instruments chose to work with Head Start instead of the public school system, and how you happened to pick the particular neighborhood in which your center is located.

Response: We are working with the public school system. We adopted Frazier School, where most of the children go, at the same time that we initiated the Cone Head Start Center collaboration. We think the public school system is enormously important in the development of the capabilities of the children. We thought it would be easier to start fresh with a new model and new staff. The teachers and center director were experienced in Head Start. We wanted to encounter all the difficulties of startup, to see if we could still make an impact. We are initiating a new center, which is planned to serve a Latino community in Dallas. We have chosen a site in a Latino neighborhood. We have raised money with other foundations to construct the Head Start facility; however, it will be staffed and run by Head Start.

Response: One of the challenges that we faced in consideration of different neighborhoods was that Texas Instruments had expressed an interest in making the center available to all the children in the neighborhood, the neighborhood being defined as an elementary school attendance area. We received a waiver from Head Start that allowed all children to attend, regardless of income. Interestingly, we have only had two children in two years whose family exceeded the income level. As a result, we have not had to use the waiver. However, we had to study different poor neighborhoods of Dallas and find a neighborhood that did not have a preschool program operated by a nonprofit or for-profit organization, because we did not want to put people out of business. There was no other preschool program in the Cone Head Start neighborhood.

Question: I was moved by the exciting presentations. I have a fairly specific question to the Texas program, but it also addresses the metaphor that Ron Herndon used. First, you made the point that you tried to address all the health care needs of the children, with the nurse-practitioner either providing the care or working with parents to get the needed care. Then later you talked about social workers moving parents into employment, often full-time employment. It was impressive. How are you going to continue to fund the health care for the children, if women are moving off Medicaid or government-funded health care. Have you given any thought to trying to collaborate with employers to provide health care benefits for the women who move from welfare into employment?

Response: You have identified a key problem. At the Cone Head Start, children attend for one year. After six years of operation, I feel that two years would have been better. Nevertheless, the services and supports that we provide to Head Start families is going to disappear when they go into the public school system, whether they are employed or not. We do not have a solution.

Question: Would your agency, organization, or foundation be interested in Head Start grantees themselves applying directly for funding and entering into a partnership with a university, rather than the university entering into a partnership with the Head Start agency? Many times

Head Start Partnerships, Research, Practice, and Policy

when the university is the grant recipient, they dictate to Head Start programs and other programs what they want. When you enter into a partnership, you are talking about added-on value. What is it you leave after the partnership and the project have gone? What gets institutionalized, and how are people empowered so that what you initiate will continue after funding?

Lonnie Sherrod: There is no inherent reason why a grant from our foundation could not go directly to a Head Start agency or any other kind of public service organization, as opposed to a university. In fact, we have funded a number of projects that represent partnerships. In some cases the grants have gone to the university, and in other cases to the partner organization. However, the one example I can think of was an evaluation of a service learning program in New York City called the City Volunteer Corps, in which the Corps thought it would be important that they be the recipients of the grant, even though the investigators doing the research were at the City University of New York. As a result, the grant went to them, and then they ended up not subcontracting to the university for their portion of the costs. The William T. Grant Foundation funds only research. It has to be a research application that comes to us. Because it is evaluated as a research application, to be competitive for our funds, it has to be an application that is put together by people whose primary livelihood is research. What that means is that it is frequently more efficient for the application to come from the university, and for the university to receive the funds. They understand how to put applications together, and they understand the flow of money. For example, our kind of grant management apparatus is set up primarily to deal with universities, in that the timing of our cash payments is not of tremendous consequence. Universities are rich enough to afford that kind of slowness of cash flow. Organizations that are dependent on getting a check from us in order to pay their payroll provide a particular challenge for us, sometimes creating bureaucratic problems.

Response: From our standpoint, if a Head Start director in one of our plant cities came to us and told us that they were determined to improve the educational aspects of their Head Start program by conducting an evaluation with the help of a university, we would be thrilled and shocked. However, if you are going to do research, it is mandatory to have a university associated with the research. Unfortunately, you have identified a problem that is real. The Urban Community Services Program of the Department of Education and HUD's program that promotes university/community partnerships all require the university to be the principal recipient of the grant. On the other hand, Healthy Start was mandated to Health Departments.

Response: We as a university unit are often perceived by funders as an independent legal entity that can be accountable and is independent of the principal players in the collaboration. Therefore, they favor giving the money to a university. Here is a legal and business entity that is designed to do the job, and so it is done as a matter of preference, but there is no reason why it could not go the other way. For example, we do so much business in Pittsburgh that foundations do not want to give us any more money. So what happens is they give it to an agency, and the agency turns around and subcontracts with us, so that it does not appear on the foundation's ledger as a grant to a university.

Response: There is another kind of a partnership or collaboration where we do not want the money to go to a university. I was asked to organize a group to submit a grant to coordinate Early On services for the State of Michigan. I brought two colleagues, one from Wayne State

Head Start Partnerships, Research, Practice, and Policy

University and one from the University of Michigan. Together we directed three graduate training programs in infancy in the State of Michigan. We came together and have been talking for three or four years about how we can coordinate our three graduate training programs in infancy to make maximum use of resources, but we have never been able to pull it off. We wanted to avoid three universities being the obstructions to us getting together and trying to coordinate a program. We found a private, nonprofit corporation, the Michigan Public Health Institute. It will end up getting that grant and then subcontracting it back to the universities for those portions of the project that relate to those specific universities. In this case, if we had tried to work through the bureaucracies of three state institutions, with their indirect costs, we would never have accomplished it. What is also nice about it is that the nonprofit corporation already has an existing agreement with the three research-intensive universities in Michigan for a maximum 20% of indirect costs. This means that more of the money coming from the state is now going to go into direct training and technical assistance for the trainers.

Response: There is an implicit point here that maybe we should make explicit. The typical university researcher, particularly if they are reasonably successful, will have considerable experience and an expertise in grantsmanship and in fundraising, probably more so than the centers or programs that they work with. That is a kind of expertise that they should share as part of the partnership, even if it is not for research funding, but for bringing in program support.

Question: How did you arrive at the title "Applied Developmental"?

Response: We started out with a group of 30 or 40 people that met at the American Psychological Association four or five years ago. It was headed by Celia Fisher from Fordham, along with Richard Lerner, John Murray from Kansas, and a host of others. They came from basically two disciplines: developmental psychology and human development, or family/child ecology—that branch of developmental. Their objective was to take the basic research of developmental psychology or child development and move it into an applied developmental psychology. There is now a journal about that. It became clear to them early on that there were many other social and behavioral sciences that had an impact on human beings, and human development was a much more interdisciplinary field. So the science got added on to replace psychology. It is developmental because there is a heavy emphasis on longitudinal methodology and longitudinal design. We would have difficulty being a partner with the Texas group in Applied Developmental Science. Why? We would have to find some kind of objective that we could focus on for a five-year period. However, you only have the children for one year. We probably would have worked out a strategy where we could continue to follow the children over a period of time. We think in terms of five years as a commitment to our community partners. It is science because it is not social service. Universities do not do service; universities do scholarship. What we are trying to do is bring the technological skills of the social and behavioral science out of the university and fold them into the ongoing programs of the community so that it is science-based. At Michigan State we talk about outreach research, outreach teaching, and outreach service.

Comment and Question: One good thing about this conference is it is showing us how much the lines between science, service, and policy are blurred. How much of the impetus was bottom-up, how much of it was top-down with provost leadership, or how much of it was related to your state politics, the general assembly wanting to see you do something for these tax dollars?

Head Start Partnerships, Research, Practice, and Policy

Response: I think every legislature in the United States wants to see us do something. About four years ago, the Provost of the university provided the resources to bring Celia Fisher to campus. I was asked to chair a group of faculty who basically turned out to be my interdisciplinary faculty in the infancy program. We met with Celia for three or four days and then wrote a brief report to the Provost, saying that if you want us to give you a reasoned proposal, you should put us together for a year and let us explore this and see what is going on. She did that, and that resulted in all the things we are doing now. The provost does provide some support for the graduate program that will be in place in January. The Vice-Provost for university outreach provides us with half my release time, all of Annette's salary, and some seed money. The seed monies are like \$5,000 here, \$10,000 there. It is in the form of half a graduate assistant that we can offer to a faculty member because we want that member to join a particular program. We had two partners here to describe projects because neither Annette nor I are directly involved in these projects. We are basically brokers. We bring faculty from the campus to the table of community partners that have contacted us. We provide the general support services to get the faculty and the community person to begin collaborating. If the marriage is good, they are off and running, and we are out of the picture. We require research rounds so that there is a periodic feedback session where all the stakeholders come together and evaluate what is happening.

Response: Back to the issue of the name, ADS. I would like to add another perspective. You ought to be in a room of non-university people and introduce yourself and your colleague as representing Applied Developmental Science at Michigan State University. I do not know whether it is a sucking sound or not that you hear, but it is glazing over of the eyes, and the whole audience looks like this means nothing to them. We have consciously shortened it to ADS at MSU and talk about it in terms of behaviors and principles rather than expect it will mean something to a whole universe of people.

The other thing is that you asked whether it was a bottom-up or top-down initiative. We had one bad experience. It was a large 17-year evaluation proposal that we were involved in across disciplines. Our big mistake was working through department chairs and institute directors and giving them a front-line role. In reality, the proposal represented 17 years worth of money. We want a front-line role. We were terrorized. We were fighting each other. We became people we did not know. A lot of that was because we were in this arena of heavy-duty cutthroat politics over the funding.

Response: I want to add a good perspective on the interdisciplinary, cross-cutting nature of Applied Developmental Science. I will give a concrete example. Asset mapping, or asset-based approaches was one of the top issues on our joint plan that we developed. We decided to have a panel presentation or workshop in our community provided by people from Michigan State University. Some of the disciplines that were involved in that were urban planning, geography and one of their geographic systems experts, political science, the Institute for Public Policy and Social Research, and then our own local extension service, Cooperative Extension, which is also a part of the university. That gives you a taste of how we were able to take advantage of the various departments and disciplines. I look at it as sort of a department store, and we get to pick what is appropriate for the project that we are working on.

Comment: When Hi first came to one of our meetings and tried to sell ADS to us, it was a very ecumenical process he depicted. Practically everybody in the university was invited to be

Head Start Partnerships, Research, Practice, and Policy

part of it, including entomologists. It is a little hard for our staff to understand the connection between entomology and what they were doing, but we are still partnering. Another example is in Flint, where there were several years of relationship between the president of the Mott Children's Health Center, Roy Peterson, and work that he was doing and leaders at the university. I do not know how this applies to the other partnerships, but that one was built on strong personal trust.

Comment: I have four colleagues in the Department of Crop and Soil Science who are part of ADS, as is their department. They have been studying food production in African villages for the last 25 years, and as part of that, they look at the social structure of the village. They are doing applied developmental science, so they are part of this. In that sense, we have defined applied developmental science in a much broader way than my colleagues around the country, who are also doing applied developmental science.

Response: There is no one way to do this. You have to "sniff out" what will work in your community. For example, even though Hi's and our units are very similar, to an outsider they are also very different. It helps if you have a top administrator who blesses, supports, and even gives you money. We started 10 years ago as a faculty-up enterprise. I have had five provosts and three chancellors, and none of them have been into this program. We operate under the philosophy that it is easier to ask for forgiveness than permission, and like Nike's slogan, we just do it. It can work that way—all the way down to never using the word science or research, because the people who participate in many of the programs we operate are so sick of science and being used in science projects that if we characterized anything we did as science, we would not get to first base. So there is no one way to do it. You have to assess your resources, assess who is in favor of you, and do the best you can.

Response: The work at Cone Center is done through the Community Services Development Center of the School of Social Work at the University of Texas at Arlington. The Community Services Development Center provides an internship site for social workers who specialize in macro practice; that is, organizational practice. The center works with many different organizations that come to us: health, social services, and education. All three programs come ask us for assistance either in developing a new program or evaluating or improving an existing one. However, our work at UTA is done through the School of Social Work, with the tentacles reaching out into the community as a whole.

Question: I have two questions. The first is for the Cone Center. You described a Head Start center with lowered family service caseloads as well as a substantial amount of health services. Now that you have mentioned that it is the School of Social Work with whom you are connected, I am particularly interested in knowing if there are some special strategies that you are using in family services that you think perhaps are making a difference for the families?

Response: We are very candid at Cone. We find that that is the way to identify weaknesses and improve the program. I wish that I could tell you that the Social Services program is doing innovative things. They are certainly looking toward the employability of parents. While that is not unique, it is in response to the goals that the parents themselves set. I would like for the Social Workers to be able to spend less time putting out fires. They spend a lot of time in emergency assistance and case management activities. While talking with them about the benefits of

Head Start Partnerships, Research, Practice, and Policy

spending time working with parents on longer term goals, I realize that it is a lot easier to say than to do, when the parent comes to them saying, "I am being evicted from my apartment today; what can I do?" Due to the extreme poverty of the parents, they are always right at the edge of disaster, and several families fall off into that terrible black hole every day.

Response: We use several strategies. The first strategy is to do a family needs assessment that gives you a baseline. Then you can start working on where we need to go. The second strategy is the caseload that was mentioned earlier this morning. If you have 200 families to say grace over, you are not going to do anything but put out fires, and even the big fires are all you are going to attack. However, in this case, Mary recommended a caseload of 45 families per social worker, and that turned out to be a workable number. If you run that number up much, you start to lose ground, and pretty soon you are not doing anything. The third strategy is to have the social workers at the preschool so that every morning and evening when the parents come, the social workers are there and they see them. "Did you get your application in today? Were you able to get downtown and check that thing out? Can I help? Can I drive you down tomorrow?" It is a continuous process. It is not just hit and miss. You do not come back a month later and say, "Why didn't you do that?" The fourth strategy is to keep the center open extended hours so that the parent can get a job. They can bring their children in the morning and pick them up in the evening, and work all day and not have to worry about them. It all fits together. Our program would not realize the results that we have without those strategies.

Question: When Texas presented their data, it clearly showed 13% of parents employed before you entered into this partnership, and as a result of two or three years, it is up to 39%. Are there any interventions other than the social service type that can foster such improvement? Many parents feel worthless, powerless, hopeless. They have been out of work for so long that they lack self-esteem. You have to provide an intervention to help motivate and stimulate parents to believe in themselves and go to work.

Response: Perhaps the University of Texas at Arlington has a broader perspective of what social work is about, but the prevention of problems is a major element of good social work practice. Helping the parent to secure employment that is going to make it possible for that parent to be self-supportive is pure social work.

Comment: This is an example of where we need to be very systematic about the parental intervention. We tend to look upon parent populations as homogeneous, and we already know that they are not. For example, it was 20% that you reported that you moved into employment. For that 20%, the only thing they needed was a safe, reliable place to put their children during the day in order to go to work. There may be another "X" percent who need remedial education and, in some cases, mental health counseling, and so forth. These are the kinds of thing that you may learn from this project—to differentiate the population and their needs for a more expanded array of services.

Response: The paid parent program is a program that is offered to parents at Cone who are not employed and who are interested in learning how to get a job and how to act on a job. It is especially helpful for first employment experiences. They come to Cone, get employment training, but also receive assistance in the centers. Different parents do different things at the centers:

Head Start Partnerships, Research, Practice, and Policy

help in the classrooms, help in receptionist-type activities, and help the nurse. It gives them employment-type experiences that are extremely helpful. Two of our teachers are graduates of the paid parent program.

Response: Let me share something from my days as a manager of sales people. There is nothing more motivating to people than putting numbers up on the wall at a sales meeting to see who had been the most successful, who was the next, and who was at the bottom. After a few sessions of being down at the bottom, one starts getting uneasy about one's job. One either quits and goes somewhere else, or starts figuring out how to sell the products. The graph that we showed you is shown to us by the social workers at every one of our operating reviews. It boils down to peer pressure. The social workers seem to respond by working harder to change those numbers. It seems to be a matter of pride. We did not set those goals. We tried to set some goals for getting parents into the workforce, into training, getting their GEDs, or into college. However, we had no way of knowing what was a reasonable goal. We just picked numbers and started. Let me assure you, we never picked numbers like you see here. It is program staff setting their own goals, being measured and evaluated, and showing in public what they accomplished.

Question: Ron, you talked about the importance of looking beyond the United States for answers and, perhaps, forming partnerships and collaborations that reach across international borders. Can you talk about how that might happen and what we might find out if we take those steps?

Ron Herndon: I think the "how" is showing interest in learning what the rest of the world has to offer. For too long we have been arrogant about much of what we do in this country, presuming that whatever it is, we are number one. Once we have the motivation to look beyond the borders, we will find a great deal occurring around the world, and especially in third-world countries. In Central America and South America you will find some parent involvement programs that are doing interesting and successful things. Once you find out about them, the trick is to determine how we may make them a part of what we do in this country. That is where we become somewhat reluctant. Then start talking about societal changes that are necessary, and we frequently stop short. Demonstrations and pilot projects are nice, but once you talk about societal and institutional change, you start running up against politicians and other institutions. Frequently, they are fond of pilot projects, but they are not as fond of communities beginning to ask questions and demanding the kind of changes that will make them uncomfortable. It is a question of whether you want to give a man a fish or teach him how to fish. How far do you want to go in making sure that he learns?

Comment: I am going to respond to the question. At this conference I presented a paper about a program in India, and some of the most significant strategies that were used and served to make that particular program a success. Because India is a vast, rural, tribal-based, third-world country where there are not too many resources, a lot of emphasis is on integrating services of other programs. This program is run by the central government, but they also utilize the services of a health program, which is mainly the responsibility of the state. As in Head Start, the components are preschool education, health care, and immunization. The training of the functionaries from the two programs is together, and they coordinate with each other. Another point is their

Head Start Partnerships, Research, Practice, and Policy

community development approach. They selected a woman from the community whom people could easily accept. Some of their strategies seem to be useful.

Response: I would like to disagree a bit, or add a cautionary note. I have not talked at all about the theory, philosophy, and the pedagogy that underlies Applied Developmental Science. However, if I did, you would hear me talk about context as an important ingredient. We try to take context into account all the time. There are at least two dimensions of context: within-culture variability and between-culture variability. It is important for us to be knowledgeable about human development, not just development in the United States. However, we are not context sensitive when we have a program that works in Detroit, and we try to put it into place in the upper peninsula of Michigan, which is a rural area, or we have a program that is successful in a rural area, and we try to take it into the inner city. The contexts are quite different. We have to analyze what it is about the new situation that may require changing or modifying a program, in order for it to successfully develop in that other context. From our perspective, that means you would have to get the people that live in that context involved in the evaluation of that program before you begin to implement it. That is what we mean by a shared partnership. There would be discussion all along the way.

Ron Herndon: For those of us in Head Start, that is not an issue, since Head Start is locally controlled and parents are the ones that make the policies, and the program is set up to meet the needs of the communities. My point is that so often we do not look beyond our own shores for successes, failures, experiences, or people that can be helpful to the jobs that we do. In many cases we do not even look beyond our own cities, let alone our own states. There is no debating on that. That is what we have been doing for 30 years. Let me add something about intervention. If nothing else, for the last 30 years, it has been shown that intervention works. However, nobody ever talks about how we can set it up so that a community does not need an intervention program any longer. After 30 years, if people are still not participating like everybody else, and we said that that is what we want to occur, then there is something wrong. I think that what is wrong lies beyond their communities. Those are the issues that do not get a great deal of attention. You come up against some fairly powerful institutions that are a lot tougher to try to change, and we do not do a lot of research on them. It is easier to do it on those that are still trapped. Sooner or later, if we are serious about helping people get out of these circumstances where they need intervention, we need to research those institutions that are not functioning in a democratic way to allow them to act and feel like everybody else in this country who does have the privileges of citizenship.

Question: I have been doing some work with Head Starts on welfare-to-work support activities. I have worked in Los Angeles and in rural North Carolina with women who are trying to move off of welfare into stable low-wage jobs. In an open discussion group with these women, the kinds of things that arise have to do with wage-per-hour violations, workplace safety, sexual harassment, unequal pay, things that if you pursued them would end up potentially creating tensions with the community/employer partnerships that you are trying to develop. How do you deal with these issues within the context of a Head Start setting so that you are not avoiding them, but you also are preserving the possibilities for partnership that we are looking to foster?

Head Start Partnerships, Research, Practice, and Policy

Response: When it gets to points of confrontation, most of us duck. What we frequently end up doing is following a rugged individualist approach, trying to give the individual family enough armor to be able to take on City Hall, the school system, and other institutions by themselves. Everybody else in this country works in groups: trade associations, university associations, teacher associations, unions. That is how they get their needs met. Yet we keep teaching people to do it as a "rugged individual." How do we now go back to how we were born? Head Start, along with other intervention programs, was born as a result of confrontation. How do we teach low-income communities to confront institutions? I will start with public schools. Most of us agree that they do not function well for many children in this country, middle-class or otherwise, but certainly they do not function well for low-income children. However, Head Start's approach has been to send the files, to look at graduation rates, dropout rates, and everything else about the school that says this school has not been a healthy institution. We start talking about what we can do with the individual family. We may very well be able, through intervention, to do some great things with individual families, but the institution itself remains unchallenged in any public way.

Response: There are some interesting models for more collaborative work. In Greensboro, NC, there is a project that has the theme of sustainable communities. It is working with K-Mart and K-Mart employees, with community organizations, and churches to define roles for institutions in this wider context.

Response: We have done it, and it has worked. We have challenged institutions that did not hire people from our community, and we got them to hire them. Until we get to the point where institutions will look at citizens from this community like they do from more affluent communities, we are going to be back to square one. That is the challenge—to hit these institutions so that they become more sensitive and know that we will respond. To the degree that we do not, as a society, we will at the same time be trying to come up with intervening programs to help children and families.

Comment: I was trying to visualize Head Start solving problems with banks, the community, and the workplace. I am not sure that that is the best strategy. Head Start, at least in our community, is an extremely well received institution. If we wander out of our own area of expertise, we are going to take a chance on creating a negative image for Head Start. I am not saying all these problems do not exist; they do exist. There are a lot of people that are working to try to solve these problems. I just do not know that Head Start would benefit by broadening its area of pressure in our community to cover all those bases. That ought to be discussed seriously before we entertain such an idea.

Response: Fade-out cannot be attributed to the condition of public schools alone, but also to the condition of the community. If we do not affect the environment from which the children come, if we are not doing anything to change the communities that they are going back into, the children will slip right back into that barrel of grease that Ron talked about. The issue is how we at Head Start can effect change within the community, within the environment from which our families come.

Response: Head Start is moving away from being a social movement to being a partner in the business community. We are seeking out those businesses and institutions that can enhance a

Head Start Partnerships, Research, Practice, and Policy

community by providing employment and other opportunities. We know we are effecting change, but we also know we have to be a partner with the business community.

Response: You probably do not know this about Dallas, but right now we cannot have a school board meeting of the Dallas Independent School System because the Black Panthers, the NAACP, and other people who support those organizations come to the school board meeting en masse and chant and talk and yell to interrupt the meeting. We have so far avoided armed conflict, but I would not be too surprised if we had that. The Black Panthers have threatened to bring weapons into the boardroom of our public school system, and the police have said if they bring weapons, they are going to have more weapons. We are building a little war here. This does not sound good to me, but maybe something good will come out of it. The issue is that we do not have enough African-American participation on our school board. As a result, you tend to get decisions made by the White/Latino bloc versus the African-American bloc. We have three African Americans and five Latinos plus Whites. We get five-to-three decisions all the time. That is the issue. It is not easy to solve because all these people were elected to the school board. Head Start could go down there and yell and chant, but that is not the right thing to do. Head Start has a mission. We need to keep working on our mission. We will change this thing eventually.

Response: I said this morning that many of the problems we confront stem from disconnection. One point is that I do not think we as communities need universities to tell us that the bad outcomes that we experience derive from biologic bad luck, poverty, social inequity, and misplaced values, that children need nurturing, or that adolescents cannot be saved. However, we do need a vision and a process by which we can achieve that vision. Universities have a role to play in that. I want to give you an example. Tomorrow Dr. Peterson from the Health Center will be speaking in the plenary session about an organization called Priority Nineties. It is a coalition of 120 organizations and individuals focused on improving outcomes for children and families in Genessee County. It has about a five-year history and it collected data, and he is going to talk about the transformation from data to policy. It is not a panacea, but it is a process that shows some promise, where you have dialogues in communities across the gulfs of race, age, and income. Clearly there has to be more dialogue in communities. In Genessee County, we think of the border of Genessee County as the border of our universe. For the disconnections between city center and suburb, adolescents and seniors from the mainstream, what can we do to bring about reconnection inside that universe? A process that might point the way in part is this Priority Nineties as a vehicle for communication around the issues.

Response: Communities have to be taken seriously. I hear what you are saying when you say there is a lineup in front of the meeting because that voice has not been heard. It is not that they are trying to choose a tactic that will bring violence or any other negative force to bring about change, but that has been the mindset. I am not familiar with what is going on in Dallas, but I do know what is going on in Ohio and other places in terms of trying to find that middle ground so that all voices may be heard. People want to be taken seriously, and Head Start has proven that over the 30-plus years that we have been in business. It is about making change and making sure communities' needs are met. If the intent of these partnerships is to bring about some change in communities to move them from impoverishment, we need to challenge businesses, because it is Head Start people who are coming out of the communities and working in the businesses.

Head Start Partnerships, Research, Practice, and Policy

Ron Herndon: Head Start and people who have been in it for the past 30 years have shown that low-income children and families can do quite well if they have opportunities. There are examples all over the country. However, what we find today is that we have more children in poverty, and the poverty has increased, especially among the youngest children. In 30 years, Head Start has done fine, but we are not living in isolated islands in our communities. If we do not begin to figure out how we can take what we have learned in Head Start and quickly begin to impact the institutions that shape our families, then things will get worse. There is more violence, more drugs, more teenage pregnancies today. Head Start does not have all the answers, but we found a few. To the degree that we can share those answers with the rest of the community and do it quickly, we will find these islands getting smaller and smaller.

Several years ago, our Head Start program, at Sarah Greene's recommendation, got in touch with Tom Peters, who wrote the book, *In Search of Excellence: Lessons from America's Best-Run Companies*. We told him that we think what he described in his book was very impressive. We implemented it in our Head Start program, and we thought this could have some impact on public education. We brought together some of the most successful principals in this country who are educating low-income White, African-American, Latino, and Native American children. We asked them to tell us what works.

We then created a video and a book endorsed by Tom Peters so we could share the information with others. Once we produced the video, we brought people together, including a principal from Dallas, TX, principals from small towns and big cities. They emphasized two points. One, they had their children achieving at or above grade level. Their colleagues in their own towns did not believe that what happened really happened; they thought their children cheated on the tests. Two, even though they were successful, the school system did not insist that their colleagues or other schools replicate their successes. Once they left those schools, they went downhill to where they were. We distributed this information all across the country.

We then were determined to do something even further. Everyone is talking about international standards. We brought in people from around the world: a man who runs education in Germany, a man from Japan who runs all the technical high schools, a woman from China who runs the only private primary school in China, and others. We had them meet with these principals who are doing well in the United States. Again, we came up with a road map of what works: this is what you have to do if you are going to get to international standards, and this is how you are going to do it quickly because you are not going to have forever. We got the man who runs the Bank of America to write a letter to all the big businesses in this country and say this video makes sense; it is a road map. Nike helped finance it. We got the then-President of Nike on the video talking about how this makes sense. What do you think has been the impact on the system of public education, not only in Oregon but across this country? Zero.

In the Head Start Performance Standards, it still says Head Start programs are supposed to address community problems that impact our families. That is our charge. We are morally and ethically bound to this mandate. My contention is that we are not doing it. We think that our mandate stops at the point the parent and child leave our doorstep, and we do not see our mandate going community wide. That is the challenge that we face. If not, in years to come these problems will geometrically get worse, and we will be sitting in our little corners frightened about what is occurring around us: more violence, more crime. We will be wondering how we are going to get our children in and out of classrooms without seeing more destruction. We are going to have to translate what we know to other community organizations very quickly.

Comment: I have been struck all week that Head Start is still one of the best-kept secrets in the United States. It has become an us-and-them issue, or maybe it always has been an us-and-them issue. Politicians and John Q. Citizen look upon Head Start as "that poverty program for those children," not "my children," not for middle-income people. In reality, if we are meeting Performance Standards and better, we are providing a quality program from which every child in the United States could benefit, whether their parent is extremely wealthy or the neediest of the needy. We do not do a good enough job of letting people know how vital a program we operate.

■ Case Studies of University/Community Research Partnerships

Chair: Faith Lamb Parker

Discussant: Richard Gonzales

Presenters: Ayman El-Mohandes, Allen Herman, Vanella Crawford, Victoria R. Fu, Ann J. Francis, Patricia P. Marickovich, Kari Schlachtenhaufen, Charlene Firestone, Bertram Stoffelmayr, Regina M. Miller

Representatives from four university/community partnerships presented their collaborative relationships, the strategies they used to ensure successful implementation of their projects, and the issues that arose when researchers and practitioners attempt to work together in collaborative ways.

Each partnership was represented by more than one of the "stakeholders," including researchers, practitioners, and funders. Each partner presented from their viewpoint, the development of their collaborative effort, both in terms of theoretical framework as well as practical applications. The nature of each partnership was explored, including how the evolution of the partnership guided the development of the research itself, from the actual design of the study to measures selection and or development, to interpretation of results, and to dissemination activities.

Other concerns that were discussed in the presentations included authority and organizational hierarchy, fiscal accountability, leadership, roles and responsibilities, competing needs and goals, power relationships, cost benefits, and validity of research results.

The discussant, Richard Gonzales, raised several interesting issues regarding partnerships among researchers, practitioners, policymakers, and funders, including 1) the need for all "stakeholders" to feel that they have a "say" in what happens in the research partnership, 2) the importance of choosing partners who are willing to do their share of the work; and 3) the importance of keeping open communication among the partners to foster collaboration and reduce misunderstandings, avoid goal and priority conflicts, and reduce cross-discipline confusion often related to language and approach differences among the partners in their daily work.

Building Partnerships between Head Start and the Community: A New Vision for Collaboration in the 21st Century Victoria R. Fu, Andrew J. Stremmel, Ann J. Francis, Patricia Marickovich

A renewed call for meaningful evaluation and research of comprehensive, collaborative intervention services in this nation is also reflected in Head Start. Bane called for the formation of "learning partnerships" between Head Start, parents, service institutions, university researchers, and policymakers to work together to meet the needs of families and children. The Advisory Committee of Head Start Quality and Expansion endorsed community-based approaches to research and evaluation.

There are many challenges in conceptualizing and studying comprehensive, collaborative services due to the "complexity, flexibility, the nature of collaborative effort, and the convergence of different disciplines. Complexity derives from the sheer number of players, stakeholders, and levels of the system, as multiple services lodged in different agency or disciplinary contexts, each operating from its own premises about good practice..." The process of negotiating these challenges is an important part of the present study. The main purposes of this study are to 1) document the formation and development of a Head Start/university/community collaborative to identify issues of concern and design, and implement a research/evaluation agenda; and 2) provide quantitative and qualitative data that will enhance knowledge about research and evaluation of comprehensive, collaborative services.

Head Start Partnerships, Research, Practice, and Policy

This presentation was limited to sharing with the audience an overview of theoretical considerations and the early process of implementing a model for Head Start/university/community (HSUCE) collaboration. A major assumption of this collaborative effort is that a value-based, participatory approach to evaluation, one that engages the community and, in particular, family participants, in the design, implementation, and evaluation of a program, empowers the community and enhances the efficacy of the program. Therefore, the nature of the collaborations is an area of inquiry to be considered in the research and evaluation design.

The HSUCE model reflects the principles of the Development-in-Context Evaluation model (DICE) and the visions of leading Head Start researchers and practitioners. This model promotes an approach to participatory research and evaluation that builds on the values, perspectives, and experiences of Head Start staff, parents, and community service organizations.

A history of collaboration between the Head Start program, Virginia Tech, and service organizations to serve diverse families is the strength of this collaborative. This caring partnership brought the players together to forge a "formal" collaborative, committed to enhance Head Start services.

The concept of collaborative conversation is used as the primary method of inquiry. Collaborative conversation is both a method of longitudinal research and a means to promote change. In the process of collaborative conversation issues, questions and insights that will guide the direction of the project are beginning to emerge. The following kind of study will inform the construction of an evaluation/research agenda that will include 1) qualitative descriptions of children, families, staff, and organizations undergoing change; 2) quantitative and qualitative analyses of aggregate effects on children and families; and 3) analyses of data from management systems that track families' access to, and use of, multiple services.

Collaboration of a Foundation, City Government, and Two Universities in the Design, Delivery, and Evaluation of a Family Support Program

Bertram Stöffelmayr, Kari Schlachtenhaufen, Charlene Firestone, Barbara Wash

The presentation probed a particular challenge for the ongoing Detroit-Skillman Parenting Program's (DSPP) four collaborating institutions: the melding of qualitatively different institutional systems, each one introducing different organizational cultures, and, as it turned out, conceptually different notions of how and why the project's intervention would impact the families it aspired to affect.

The program's primary goals were to strengthen families and to improve family functioning. The program was designed to help families who attended Detroit Health Department clinics, or who sought help from Detroit Health Department Public Health Nursing Service (DHD-PHNS). The decision to integrate this family support program into Detroit Health Department units was crucial for the success of the intervention. At the time the Skillman Parenting Program was initiated, 93,000 individuals used DHD clinics each year. In addition, effective community outreach had already been well established by DHD-PHNS.

Although locating the parent support program within DHD was crucial for the program's success, the decision to do so caused a major administrative challenge. A new organization was constructed and implanted into an established one. Disparate organizational cultures (i.e., DHD's central office, Wayne State University, DHD clinics, and Michigan State University), each with their own fiduciary agencies, had to be encouraged to coalesce. New lines of authority had to be established within DHD and with outside agencies. An awareness and understanding of how

Head Start Partnerships, Research, Practice, and Policy

money would flow, who would have authority over whom, and what cooperative relationships would need to exist had to be developed.

During the presentation, a diagram was presented showing the complexities of the interactions of the collaborating organizations. For example, Skillman funds, although they flowed through the health department, were disbursed mostly by fiduciary agencies. The Detroit Skillman Parenting Program (DSPP) Administrator was accountable for the funds, but not directly responsible for their distribution. DSPP initiatives were also supported by DHD funds. DHD was not only the organizational structure in which the program took place, but DHD also contributed staff and other resources.

Related is the issue of authority. The DSPP Administrator was held accountable for the performance of all participating units, but only some of the units reported directly to her. There was some shared authority arrangement over other units. In addition, for DSPP to succeed, many organizational units, individuals, and groups had to collaborate outside the context of hierarchical relationships. The entire project took place against the backdrop of relationship-maintaining communication between the Foundation, DHD, and Wayne State University.

Throughout the five-year duration of the project, special efforts on the part of the DSPP Administrator and the Foundation were made to assure cohesive and collaborative work towards agreed-upon program goals. A particularly dramatic effort was a set of meetings attended by key program staff that took place at the beginning of year three, resulting in a reaffirmation of program goals and objectives.

Community Partnerships for Brighter Futures for Children and Families

Regina Miller, Scott Johnson, Audley Donaldson

This presentation described the development of an evolving partnership between an urban university, Head Start, and a community agency by the name of Family Resource Center, that brought together people of diverse backgrounds, roles, expertise, and responsibilities to create stronger programs and a healthier community. The vehicle for this partnership was science learning for teachers, children, and their parents. The project identified ways in which each of the participating agencies and institutions added to the benefit of the other without duplicating efforts. Monies were able to be used for a greater variety of purposes because none of the programs had to spend funds for the same purposes. As a result of the partnership, the roles of programs delivering service to children and families, as well as training and education to those providing the service and education, were expanded to cross the traditional boundaries of each of the partners.

What has been learned is that the role and responsibility of the urban university is to move beyond the traditional format, which has been focus on and activities for delivering the traditional form of education to the community surrounding the university. The educational needs of the community need to become part of the planning of the university and its ancillary programs. The outcome of such programs is that the community surrounding the university becomes part of an educational environment that may not have been accessible to the individuals of the regional community through the traditional ways people become part of a university community. The regional learning community and the university are both enhanced through the process.

The advantages of partnership extend beyond academic learning. Community resources are enhanced and extended through collaboration. The Hartford Head Start program was enhanced not only in the impact the science training had on those who participated, but in the connections made with the University and the Family Resource Center. The Family Resource Center was able

to offer a summer program that was broader in scope and accessibility than what could have been offered without the collaborative effort. Collaboration stretches dollars allocated through the application of expertise already existing within the community to a program vital to the community.

As this process evolves, there is greater potential for community ownership once federal money is no longer available, since the receiving community had a major role in the planning and implementation of the project expansion and generalization.

In order to create positive outcomes for children and families, it is essential to cross traditional community boundaries to maximize the potential of the community resources available. Brighter futures for children and families depend on the development and delivery of comprehensive and integrated services.

A Head Start on Science-The Hartford Model recognizes that each community has unique resources, which when partnered, can provide enriched opportunities for children and families. The model involves more of a process of collaboration through building connections and partnerships as a means of ensuring success and project longevity, rather than dictating a set of variables to be replicated in another community.

Pride in Parenting (PIP): A Community-Based Collaborative Research Program

Ayman El-Mohandes, Allen Herman, Vanella Crawford

The NIH-DC Initiative to Reduce Infant Mortality in the District of Columbia is a unique, city-wide research effort involving academic and clinical institutions in collaboration with the community. The research protocols developed within the initiative were designed to serve as models that might be replicated in other urban settings.

The Pride in Parenting study of the NIH-DC Initiative to Reduce Infant Mortality was designed to improve the parenting skills and health care utilization of mothers deemed at risk because of failure to seek prenatal care during pregnancy. Because of the strong need for outreach efforts with this population, a multicomponent intervention model including home visits, hospital-based play groups, and parent support groups was designed.

The model was designed by a multidisciplinary research team representative of all the participating institutions within the initiative. This allowed for incorporation of health, development, and community perspectives to intervention with high-risk mothers and infants.

An important objective for this cooperative agreement was to establish a solid and viable community partnership. This involved preliminary field testing and focus-group discussions to identify the needs and receptivity of the community to the planned intervention. Feedback from a Community Advisory Board helped to shape the nature of the intervention. This enhanced the researchers' sensitivity to the needs of the community and increased the community's understanding of essential elements of the research design.

Head Start Partnerships, Research, Practice, and Policy

■ Implementing the New Head Start Research Agenda: The Head Start Quality Research Center Consortium

Co-Chairs: James Griffin, Michael Lopez

Presenters: Donna Bryant, Betsy Thigpen, Lawrence J. Schweinhart, Virginia Okoloko, Bailie Rosenthal, David Dickinson, Francine Collins, James Houlares, Martha Abbott-Shim, Richard Lambert, Gayle Cunningham

James Griffin: I am the Federal Project Officer for the Head Start Quality Research Centers. After I present a brief overview, we will spend the remainder of our time hearing from the research and Head Start staffs of the centers themselves. As part of the new research agenda, the Head Start Quality Research Center Consortium has stated its mission as "exploring linkages among quality program practices, program performance measures, and outcomes for children and families." With the new focus on quality we wanted our research to be responsive to these issues.

The four Quality Research Centers whose grants were awarded in September of 1995, are Educational Development Center in Newton, MA; Georgia State University; High/Scope Research Foundation; and the University of North Carolina at Chapel Hill. A one-year contract also was awarded to Caliber Associates and their subcontractor, Mathematica, to provide support and logistics. The HSQRs were funded to do cross-cutting work—all four centers focusing on the issue of performance measures that look at what results we want to see from Head Start programs. Site-specific research on quality practices is the primary subject of our presentation today.

In May of 1996, we did a limited pilot of a parent interview for performance measures. At each site, we asked parents about their Head Start experience and the experience of their children. In the interview, we tried to get a sense of what, from a parent's point of view, had happened during the Head Start year that had benefitted them or their children. From now until September of 1996, the cross-cutting work will continue, and we will be piloting a refined version of the parent interview and begin exploring child and quality measures across the programs.

In September a contract for a Head Start performance measure center will be awarded. This center will have two functions: first, it will have the same support role as the day-to-day workings of the consortium; and second, it will have the capability to actually take the pilot measures that are developed by the QRCs and administer them to nationally representative samples of Head Start families.

Donna Bryant: I am joined here today by my Co-Directors, Ellen Peisner-Feinberg and Betsy Thigpen, Director of the Wages Head Start Program in Goldsboro, NC, one of our four Head Start partners. We have put together a team of researchers who have expertise in different areas. Maria Boshu is an expert in observational methodology, and most of her work up until now has been with primates. But it turns out that the observational systems needed to study primates are transferable to studying human beings. Peg Birchenal is our statistician, who specializes in growth curve analyses and hierarchical linear models, which we will need for this research. Dick Clifford and Thelma Harms are colleagues who long ago developed the Early Childhood Environment Rating Scale. Dick is particularly interested in policy-related issues, and Thelma is excellent at taking research findings and turning them into usable pamphlets, brochures, handouts, videos—things that can be used by teachers—what we ultimately want to do with this work. Jonathan Kotch is a pediatrician with a special health expertise in the study of children in group care environments. Lisa Lau, a research coordinator, has been with us in Head Start for 10 years. Joseph Telfare, a researcher in maternal and child health, is an expert in studying family and center issues within the broader community.

Head Start Partnerships, Research, Practice, and Policy

Our partners from Head Start programs are Chapel Hill; Franklin Vance Warren, a very rural area in the northern part of North Carolina at the Virginia border; Wages Head Start in Goldsboro, about two hours east of us; and the Wake Orange Chatham Head Start, which is as urban as we get in North Carolina. Three of the programs are large by North Carolina standards—about 500 children—and one is relatively small. The Wake project has only a home-based program, while the Wages program has a parent/child center, so it serves children zero to three. We are going to try to take advantage of these different program components by focusing on home visiting and early child care.

There are four major questions we are studying: 1) what is quality in each of the service delivery domains in Head Start; 2) how can we best measure quality and how do these different measures relate to each other; 3) how does quality relate to family and child outcomes; and 4) how can Head Start's current quality monitoring and improvement procedures be improved?

Decisions about our research are made with an advisory board of parents, staff, directors of the four centers, and researchers. We meet quarterly. The first year has involved getting organized within our own team and with the other three national sites, and developing the parent interview measure that we have piloted. We have compiled a list of as many observational measures that look at quality in classrooms as we could find, and have worked on an observational measure of home visits, modifying one already developed by Joseph Sparling and Barbara Wasik.

Twelve focus groups, led by a professional focus-group leader, met with Head Start staff and parents to hear directly what they think quality really is. Four of the twelve groups consisted of several parents, teachers, coordinators, and family service workers. We are continuing to organize the data from these groups, but there are a few themes that are common and some that are different across groups. The importance of communication in a quality program—between parents and staff, among staff, and between parents, staff, and program management—was one theme that all groups felt was very important. The importance of staff training was an issue mentioned by everyone, including parents. Safety was another issue named in almost every group. All groups mentioned positive adult/child interactions, the importance of what happens day to day, at ground level, when working in the centers. The themes that differed across groups also give us guidance. One is the importance of learning the basics, mentioned mainly by parents, and some by teachers. By basics they mean ABCs and 123s. We need to take into account that people in Head Start programs have different goals for their children. Building good community networks was mentioned by coordinators. Having Head Start be a presence in the community was a sign of quality that coordinators seemed to mention more than others. Family service workers and Coordinators talked about communication within the Head Start team more than other groups. When the analysis of this data is formalized, we will take it to the Head Start programs and try to turn our research into usable information for them.

For site profiles, we have developed interviews for the four Head Start Directors and the Education, Social Service, Parent Involvement, and Health Coordinators, to get information about things that can be counted; for example, how many events of certain types did you have and who comes to them? We also want information about why programs choose to do certain things. Our four partners are quite different, and we would like to chart their progress over the next four years.

We plan to use multiple measures of quality to see how they link to each other. We can potentially link this work with a new Office of Educational Research and Improvement (OERI) project that we have at the center that looks at quality outcomes for children in child care, not just

Head Start Partnerships, Research, Practice, and Policy

Head Start. Our three-year plan is to use multiple measures of outcomes to see how the outcomes measures relate, and then to see which measures of quality most highly relate to which measures of outcome. Once we find the answers to that, Head Start will be able to choose which measures to use or which measurement procedures to use. Finally, we will have to decide how to translate that information into workable documents, scales, or videotapes that can be used in the real world.

Betsy Thigpen: It is an interesting experience working with researchers. Mostly it has been good because it has helped us stretch in ways that we ordinarily would not have had an opportunity. Yesterday, some of us were wondering why we would invite these people into our programs to look at our strengths and our weaknesses, warts and all. We started off with very magnanimous remarks, such as "we want to make contributions to the greater early childhood community," but in reality, most of us practitioners have a much more self-centered motivation than that. We are enjoying having experts on site to turn to and ask what they think about something. It is wonderful to be able to get immediate feedback to what is going on in your program on a day-to-day basis.

Ed Zigler said that "too often practitioners have thought of researchers as villains and were very reluctant to open their doors to them." Our research partners from FPG have shown our staff and parents the warmest relationships. Our parents, in particular, are quite taken with people who would sit for an hour and listen to them. That is wonderfully affirming to them to have that kind of time and attention. Our staff has enjoyed that relationship too.

A couple of humorous things have happened during this process. At a meeting with parents and staff from the four sites to plan site visits, Donna had taken a good 10 to 15 minutes talking about confidentiality and assuring parents that confidentiality would be protected. She just went on and on, until one of our parents finally said, "Why do you keep talking about confidentiality? We don't care what you share about us." Another time, after an interview, a parent came out saying, "You will never believe what that person asked me. She asked me how often did I take my child to the ballet. I looked at her and said, 'Are you kidding? Where would I get the money to go to a ballet?'" All in all, it is an enriching experience. It has broadened my perspective on the issue of quality, not only in Head Start, but in all early childhood programs.

Larry Schweinhart: I will be speaking about the background, what led us into this, and the specific focus that we have, along with our plans for the next five years. Virginia Okoloko will speak about what we have accomplished in the past year. Bailie Rosenthal, the director of the Bussey Early Childhood Center in the Southfield public schools, will talk about our partnership with them.

High/Scope Educational Research Foundation has had an involvement with Head Start even before its beginning, and that relationship covers three aspects that are important in shaping our interest in this work: 1) the High/Scope Perry Preschool study with its focus on long-term effects and return on investment, which has proven so useful to Head Start; 2) the High/Scope curriculum that focused us on research on curriculum (We have our preschool curriculum comparison study, for which we now have data through age 23, that demonstrates differences in outcomes for different curriculum groups. Our book, *Models of Early Childhood Education*, looks at six different curriculum models that are prevalent in the early childhood field); and 3) a great deal of training in staff development. In particular, we did a training-of-trainers evaluation, looking at long-term outcomes from the trainings we have conducted. We had already looked at the chain of

connections from the consultant who provided the training of trainers, to the trainers who were trained, to the teachers, and, ultimately, to the children. We looked at the differences all along the way to try to isolate and identify effects of training on trainers, on teachers, and even on children. That continues to be something that we think is very important.

The High/Scope Head Start Quality Research Center will also be involved with the cross-cutting research of the development of instruments for Head Start performance measures. This and the staff development focus are remarkably complementary. The technical assistance system within Head Start is tied closely to the on-site program review instrument, the OSPRI. To the extent that the OSPRI is a faithful representation of the quality and effectiveness of Head Start, then the training will be. One of the things that can be said about the Performance Standards—both the old ones and the revised ones—is that they do not have much of a focus on child outcomes. I would hope that over the years, Head Start will move towards remedying that problem. If we can identify our concerns with respect to achieving child outcomes, we can then achieve better staff development.

During the past year, we have focused on establishing the partnership, deepening our relationship with the Bussey Early Childhood Center, and forming an advisory panel. Since we did not have as many sites and were not working with as many partners as the other Head Start Quality Research Centers, we set out to identify additional partners. We have continued to do that during 1996.

During 1997, we hope to focus broadly on the staff development literature, especially on what Head Start can do in this area. We hope to bring together research and training, particularly in-service training and staff development, and try to relate that to Head Start. During that year we also want to design a national Head Start staffing and staff development study. We have already conducted focus groups to find out our partners' concerns and thoughts they have about staff development. In the fourth year, based on the results, we want to identify and conduct action research on effective Head Start training models, identifying and documenting some of the ways that Head Start conducts training. Finally, in the fifth year, we hope to field-test and document effective Head Start staff training models.

Virginia Okoloko: I would like to describe the activities during fiscal year '96 that began our systematic multiyear study of staffing issues and effective training models. We have taken seriously and literally the perspective that this is a five-year project in research, and in order to make it as successful and useful to Head Start partners as possible, we want to involve them in the process. High/Scope QRC is working with multiple Head Start sites during the exploratory and defining phases of the research. In establishing relationships with Head Start sites, we were very conscious to include diversity of agency auspice, program size, community served, and so forth. We had already established, prior to being awarded the grant, a relationship with Bussey Preschool in the Southfield Public Schools. Through ongoing visits and exchanges between the staffs at the two organizations, we have furthered the process of defining a continuum of quality. If we look at staff development activities, it is clear that Bussey staff would be at the high end of this quality continuum. We have broadened our base with Head Start sites to make sure that our partnerships are reflective of the Head Start community. We are fortunate in Michigan, one of only four states with staffed Head Start Associations, to have that organization as a resource as we reach out to Head Start centers. They have, in turn, been useful in providing us access to Head Start centers, both in Michigan and in the Midwest region at large.

Head Start Partnerships, Research, Practice, and Policy

We are also in the process of forming a center advisory panel and have met individually with some of our members, and will be having our first group meeting as a center board near the end of fiscal year '96. A considerable amount of our energy and effort has gone toward building a framework and gathering information, not only about what exists in terms of training opportunities and staff development for Head Start communities, but also about how those resources are actually used by staff. We have worked with the Midwest regional offices in Chicago, a logical place to start since that will be the regional offices for many of our Head Start sites. We have also met with RAP and the National Head Start T & TA Bureau. They are restructuring their organization. We do not want to recreate the wheel, so we are sharing our work with each other. We will not limit our pursuits to staffing in Head Start because we take the idea of partnership seriously. Therefore, we will be addressing the entire early childhood field.

Bailie Rosenthal: The quickest way that I can give you a picture of what our partnership is like is to give you several reasons why you would want research partners at your center and how it connects to our mission of energizing families, communities, and ourselves. The most important key to quality is that you have to love what you do, and when you communicate this, other people tend to get infected with that same enthusiasm. First, it tends to spark innovation—innovation on practical things, day-to-day problems that we as directors run into regularly and that interfere with our having a larger vision of maintaining quality. For example, our center was struggling with how to report student progress in a developmentally appropriate way, and in a way that parents who do not speak the “language” could understand. We also wanted to have a way that would measure the long-term benefits of their own and their children’s Head Start involvement. Because we are part of the Head Start Quality Research Consortium, my colleagues will be measuring competency in Head Start classrooms—what they call long-term planning ability. I view that as a major force in life, and something not measured by knowing ones ABCs, but the beginning ability to organize the world.

Head Start cannot continue to use a 1960 model. We have a different world today, and many of our parents are being pressured by child care concerns and job responsibilities. We have a growing immigrant population, and, consequently, it is important to bring job training and family literacy into the program. By being part of this consortium I now see that there are many roads to excellence. Second, a very important outcome of the research and practitioner partnership is to have your program infused with new ideas that you and your staff pick up. Third, we in the field have lots of data that we sit on. I feel an acute responsibility to make sure that this data gets shared and transmitted, to leave a legacy of improving practice. Because of our partnership, I will have better tools to determine how to make that part of my everyday responsibility. Last, I think it was Ed Zigler who said that a good parent is not a good parent for one year. I add that a good partner is not a good partner for one year. This is an opportunity for us to learn to live and to grow as a family, which will enrich us all.

David Dickinson: The New England Quality Research Center is truly a consortium within a consortium. We have four research institutions: Educational Development Center where the project is based and currently holds the Region I contracts for technical assistance through the resource center and the resource access project; Boston College, represented by Martha Bronson; Harvard Graduate School of Education, represented by Consuelo Asevas; and Massachusetts Society for the Prevention of Cruelty to Children. We also are affiliated with 10 programs throughout New England, and are working with them in varying levels of intensity.

The first goal of our center is to work collaboratively with the other Quality Research Centers to develop measures and to examine the impact of quality indicators on children and families. Second, we want to examine the impact of demographic change, especially linguistic diversity on teacher/child interactions on children and their development, relationships between Head Starts and families, and on program management practices. This is a critical issue and is made clear by a forthcoming report funded by Head Start, which finds that approximately 24% of the children served by Head Start speak a language other than English as their first language.

The next goal is to develop tools appropriate for use in Head Start that capture classroom interactional dynamics. We feel that there are very few measures available for looking at what is really going on between teachers and children. We also want to develop varied models of the ways in which Head Start programs can engage in research. We are actually trying out various ways of working with our 10 programs. They will participate in interventions we conduct, examine questions with us, help us shape research questions, and interpret results. We also are hoping to experiment with having Head Start programs actually be lead investigators—where they develop hypotheses for which they want answers, and we serve as technical support to help them carry out the research.

We have a series of ongoing and planned studies. One is a study examining the impact of linguistic diversity, which is being led by the group at Harvard. They are attempting to learn about teachers' and parents' beliefs about first and second language acquisition and about literacy. They want to learn how children cope in classrooms by examining relationships with peers and teachers, and to examine the impact of classroom practices on the acquisition of English and on the maintenance of first language competence. They then want to look at how linguistic diversity affects home/school relationships and the impact of language acquisition in Head Start on home life. They have been doing classroom observations and are now turning to videotape. We will examine the videotapes with classroom teachers and discuss their perceptions of what is going on as they are looking at the tapes of children in classrooms. Another is the development of a tool for studying social and task skill development. We are working with Martha Bronson to refine her Social and Task Skill Profile for use in Head Start classrooms, to check the psychometric properties of this tool once it has been streamlined, and to examine the impact on teachers from training in the use of this observational tool. Next is the development of a tool that captures critical features of teacher/child interaction, and finding a way to code them as they are happening, instead of using audiotapes. We want to test the psychometric properties of this tool, and then look at the impact on teachers from learning it. Some preliminary anecdotal data from focus groups with teachers and assistant teachers, representing varying years of experience, revealed that it was easy to do. One nice quotation from a teacher: "It made me think about what I was saying and what the child was taking in. When lots is going on, I try to stop and listen more to the children."

Another project is looking at database and information management issues to examine program factors that affect how information is stored, accessed, and used, with special attention to computerization of information. Also, we want to examine the impact of variation information utilization on program functioning, which ties into our overarching question about demographics. We have to be able to know when communities change, because that will impact programs. Accessibility of information is necessary for programs to respond to change. We are also looking at management practices. Pat Fahey from EDC, who has been carrying out the Phase III management training, is building on our understanding of Head Start practices to develop an instrument

Head Start Partnerships, Research, Practice, and Policy

that describes characteristics of program management and indicates the extent to which a program functions in a visionary way, as opposed to a survival or crisis approach.

We are going to carry out a short-term, longitudinal study to examine the impact of multiple indicators of program quality on children and families. We will be using the tools described above—the parent interview and Bronson's tool, the verbal interaction tools, the family/parent interview, and other child outcomes—with special interest in the impact of varying densities of linguistic-minority children in classrooms. Finally, there are a variety of questions that have just begun to be formulated by Head Start programs around the region, and we are going to be supporting their emerging research interests.

Francine Collins: The Cambridge Head Start program is in a community rich with diversity. Our staff, children, and families reflect that diversity. However, despite all of our efforts to have the staff reflect the makeup of the classrooms' families, that is often a challenge. In the Cambridge community, and in the Head Start program, we represent 12 or 13 different language groups. The largest groups are Spanish- and Haitian Creole-speaking children and families. Our staff is not nearly as diverse. We are also a community rich with universities and research institutes. So we have not lacked research initiatives that have gone on in our program through the years. We are always interested in how children and families can benefit from any research that goes on in the program. However, this particular initiative with EDC and the Harvard researchers is unique in that it represents a genuine partnership between the Head Start program, staff, children, parents, and researchers.

For a long time I have wondered about how our teachers can most effectively respond to the diversity in the classroom and build upon it. It makes sense that all children and all of us would be bilingual. The goal that we have in common is that we want the children to acquire English as a second language and to become fluent in it. This sentiment is expressed by parents, teachers, and administrators. The children are immersed in an English-speaking environment in the Head Start classroom. For the most part, the teachers are English speaking, and while they try to accept the home language and to encourage its maintenance, we are not always sure how they go about doing that. When most of the children leave Head Start after a year, they have acquired English. We are not quite sure how it happened, and so my question is, "How can teachers learn to influence that process in a systematic way?" The parents are concerned about the acquisition of English and its impact on the maintenance of the home language.

The researchers have done an excellent job. They have been sensitive to the Head Start population—the staff as well as the parents—and as a result the staff has felt that they are truly contributors to this effort. They will learn the most effective way to help children maintain their home language, acquire English as a second language, and become bilingual in a world that certainly requires it.

Jim Houlares: Lowell, the program that I direct, is about 30 miles north of Boston. We serve about 498 children, but we have recently renovated and converted a 67,000 square foot building into a comprehensive child development center. We have 28 classrooms, 2 designed specifically for infant care, three large indoor play areas, a water playroom, a central kitchen, a health and wellness center, a sick bay for sick children, assessment rooms for outside resources to come in to work with children, storage areas, work-break rooms for the staff, administrative offices that include an adult learning center, and a parent meeting space. We also have two tenants: one has early intervention programs for children zero to three, and the other is a mental health clinic,

Head Start Partnerships, Research, Practice, and Policy

working directly with us, providing individual counseling for children and families, and conducting support groups.

We have a history of involvement in research, serving once on a panel with 10 other Head Start directors across the country working with High/Scope—a Head Start Cooperative Research Panel looking at a case study model for interviewing first-, fourth-, and tenth-grade graduates of the Head Start program. The report from that study will be published shortly. In addition, we did a creative art research project with Tufts University and additional research as part of our Family Service Center grant.

We felt that including practitioners in this partnership with EDC was very important. We want to know what is practical, meaningful, and important to children and families. Enhancing staff skills has heightened their ability to become involved in the research project. Some of these are observational skills: record-keeping techniques that include portfolios, case studies, and use of profile instruments; training opportunities; and self-analysis. The process of being involved has meant that the staff has input into the questions being looked at, such as what we do, why we do it, and what more we can learn. The partnership also has enhanced motivation and commitment, taught staff to work together as a team, and helped us in career development.

Martha Abbott-Shim: We have three Head Start partners: Gail Cunningham, Director of the JCCEO Head Start program in Birmingham, AL; Clarence Phillips, Head Start Director in Waycross, GA; and Patsy Thomas, Director of the Ninth District Head Start program, which covers a 20-county area in the north-central part of our state. Our project hired three full-time site coordinators, housed in these Head Start programs. Our goal is to answer the question, "What are the relationships among program quality measures, program performance measures, and child and family outcomes?" The site coordinators support data collection and document the practices within the Head Start programs that are integral to quality. In addition, we have a Research Advisory Board, an interdisciplinary group, from Georgia State University, Morris Brown College in Atlanta, University of Alabama at Birmingham, Centers for Disease Control and Prevention (CDC) in Atlanta, the Georgia Head Start collaboration office, and two state boards of education: in Alabama and in Georgia. The advisory board is concerned with community impact and broader policy-level involvement.

This year we have conducted pilot data collection with program measures using the assessment profile research version, a quality measure with five scales. We used a Teacher Belief Scale and a Family Involvement Survey, looking at beliefs of teachers and teacher aides and their perceptions about appropriate practices and family involvement in the Head Start program.

Preliminary results from the Teacher Belief Scale administered to 190 teachers and family service workers indicate that the family service workers had stronger beliefs about developmentally appropriate practice than teachers and teacher aides. Appropriate individualization was the strongest scale. This looks at the responsiveness of the Head Start staff in working with individual children's interests and developmental needs. Responses indicated that "inappropriate structure" was the weakest. That is a scale looking at inappropriate practices of curriculum being implemented as isolated areas; for example, beliefs about there being a time for art or blocks, or a time when there are no integrated curricular areas for work with individual children. The results will be used by the programs to think about how this information may influence their in-service trainings.

Head Start Partnerships, Research, Practice, and Policy

Rich Lambert: I will describe two of the initiatives we implemented this year. We began by asking people, in a qualitative interview, for their own definition of quality. We wanted to use the qualitative information to design instruments that look at the differences in perception of program environment by people in different Head Start staff positions and to use those differences in perception as a rich picture of the program environment and the quality of program management. The measures in the interviews fell into five domains: 1) teacher and staffing issues; 2) administrator or program environment issues; 3) classroom environment; 4) curriculum; and 5) parent involvement. The most frequently mentioned items from the interviews were used to develop specific items for the surveys. They focus mainly on communication between staff members, support given to staff and teachers by administration, policy setting and policy implementation strategies, and so forth. The result was four pilot surveys for administrators, teachers, policy council parents, and regional office staff. Over the five years of this project, they will be developed into measures that we can use to get a picture of a program's environment as it relates to policy and management.

The other initiative is a pilot hierarchical linear model. Multilevel nesting and unequal sample problems are very common in univariate analyses in educational research. Hierarchical linear modeling recently has been a technique that helps us deal with these kinds of issues. One of the original charges to the Quality Research Centers was to relate program, teacher, and classroom variables to child and family outcomes. HLM will be used to analyze observations of children within classrooms where we have also collected classroom observations and have surveyed teachers' perceptions mentioned earlier. It will give us the opportunity to look at the relationship between the classroom-level variables and child outcomes.

Gayle Cunningham: I will speak about some of the practical aspects of being involved in the partnership. We got over our fear of research and evaluation by actually hiring our own evaluator five years ago for the Transition Project. At that time we formed a marvelous partnership with Martha Abbott-Shim, and Georgia State has supported them as our "local" evaluators for the last five years. Since then we also have collaborated with them in our efforts to seek accreditation by NAEYC, and are very proud that we now have 34 centers accredited. We think of ourselves as a rather introspective program, working hard on quality issues and trying to be open to opportunities for improvement. A person doing on-site data collection has made a big difference. It has allowed staff to become very comfortable with having someone there all the time listening to and observing us and hiring other data collectors to come in and find out more about us. This was a Head Start trial run, but when given the opportunity to have either a portion of our classrooms observed using the classroom instrument or all of them, we jumped at the opportunity to have all of them observed. We are already in the process of taking findings from these observations and using them as we plan for staff training for next year. We are also thinking about ways that we can employ some of the projects' instruments for our own internal work with staff, particularly the teacher beliefs scale. We are considering using it with new staff, at pre-service and at several times during the year, to see if we are making a difference over time. There will be numerous other opportunities to use the data and participate in the Quality Research Center in an active way. We are looking forward to learning more about ourselves, and more about what it takes to run good programs.

Head Start Partnerships, Research, Practice, and Policy

Audience Questions and Comments

Question: I am Paul Ryder, Portland Head Start Family Child Care Demonstration. In my project I am interested in whether teachers and assistants rate differently based on their own educational level. Are you looking at this?

Answer: There are differences in the education levels of our staff. We have collected teacher demographics, and with the preliminary pilot data on various staff and classroom measures, we will be looking at those differences.

Question: Is there any plan at the present time for coordinating the activities of this group with the earlier longitudinal efforts of the Early Head Start program? Will there be a dovetailing effort?

James Griffin: We have actually built that in, to a certain extent, with John Love. He has been the prime investigator for the subcontractor and is actually the P.I. for the evaluation of Early Head Start. At this point we have a challenge working with the three-to-five age group, but we also are thinking about how to include the zero-to-three population, as well.

Head Start Partnerships, Research, Practice, and Policy

■ Early Head Start Forum

Co-Chairs: Esther Kresh, Administration on Children, Youth and Families;

Helen Raikes, Society for Research in Child Development Fellow, Administration on Children, Youth and Families

Discussants: Robert McCall, Kathryn Barnard

Presenters: John Love, Glenna Markey, Lori Roggman, Barbara Greenstein, Mark Spellmann, Teresa Alvarez-Canino

Helen Raikes: I am the Federal Project Officer for the National Study of Early Head Start, and Esther Kresh is the Federal Project Officer for the Local Studies of Early Head Start, the structure of which we will lay out. We have several purposes for this presentation: 1) to inform you of the ways we are thinking of Early Head Start research and what we hope it will do for the development of programs and policies as they relate to infants and toddlers; 2) to make clear to you the structure of Early Head Start Research and Evaluation, because it has many components and it is important for people to understand exactly what it is going to be; and 3) to illustrate the partnerships that exist. To that end we are going to have several programs and their researchers depict the partnership model reflected in the 15 Early Head Start local research projects, as well as in the national research design. Our presenters are John Love, Project Director for the National Evaluation; Glenna Markey from Bear River Head Start, and Lori Roggman, responsible for research at the Utah site; Barbara Greenstein, Director of Early Head Start at the Educational Alliance in New York City; Mark Spellmann, responsible for the evaluation of the New York site; Teresa Alvarez-Canino from New York University, the New York site; Bob McCall, part of a group at the University of Pittsburgh; and Kathryn Barnard, responsible for research at the University of Washington, Auburn, Washington Head Start site.

I would like to share the background of Early Head Start and then talk about the research and evaluation design. Early Head Start is a response to the crisis of increasing numbers of children under the age of six and, particularly, infants and toddlers, in poverty in this country. We see increasingly more infants and toddlers in single-parent households and with health and developmental issues. In response to this quiet crisis, the Head Start Re-authorization Act in 1994 recognized the need for services for families with infants and toddlers. To that end, an authorization was created whereby three percent of the Head Start authorization in 1995 would be devoted to services for families with infants and toddlers. The amounts increase to five percent in 1998. The reasoning was that we then could respond to the needs of infants and toddlers, to give them the opportunity to develop to their fullest potential.

The RFP for the first Early Head Start programs was released in March of 1995 and called for certain specific characteristics for Early Head Start programs. They would be early, continuous, comprehensive, and serve children and families in a two-generation framework. Early Head Start had four target areas: child, family, community, and staff development. All Early Head Start programs have certain characteristics in common, and yet each has developed its own response to the mandate. They enable communities to design flexible and responsive programs, while requiring that they provide some form of child development appropriate to the needs of infants and toddlers in their particular community. It requires programs to provide family support, health services, home visits, child care, and accessible services with follow-up in the community. Over 500 sites and programs from around the United States applied for Early Head Start grants. Sixty-eight programs were awarded grants in September, 1995.

The committee that advised the development of the Early Head Start, the Advisory Committee on Services for Families with Infants and Toddlers, recommended that a strong evaluation accompany the Early Head Start program. The committee suggested that we target certain kinds of research questions and look at program effects in all four cornerstone areas. They also

Head Start Partnerships, Research, Practice, and Policy

suggested that we look at for whom and under what conditions the program had effects. What were some of the program, family, and community characteristics that make a difference for particular children, families, staff, and so forth? In addition, they urged us to go even further and learn about the pathways by which Early Head Start might be expected to have an effect. That will help us be able to apply the information that we are learning more quickly to programs for continuous program improvement and to understand better how it is that our programs are working. To that end, a committee designed a research plan involving a national overarching summary study and 15 local research sites where individualized formative evaluations are being conducted to promote continuous improvement. The national study is being conducted by Mathematica Policy Research in Princeton, NJ. Mathematica has a subcontract with Columbia University; Jeanne Brooks-Gunn directs that.

We hope to learn about the characteristics of Early Head Start programs because they are so individual to the needs of each community. However, we also are planning analyses of clusters of programs, different models by which Early Head Start programs may fulfill their services. The research sites include six that have a home visiting approach; five that have a child care approach; six we are calling mixed models, some child care and some home visiting, depending on the specific needs of the families. These are some of the variations that exist in the Early Head Start sites.

John Love: The national evaluation is designed to fit and meld in with the program. We began with the four cornerstones and designed evaluation strategies that address, both in terms of the implementation of programs and the outcomes, each of these four cornerstones. The framework for the national evaluation is still being developed in collaboration with the local researchers. If you know the Early Head Start program guidelines, there are nine program principles supporting their cornerstones. We are incorporating features of these principles into the evaluation design. For example, we are designing an implementation study that measures the quality of services, home visits, parent education, child care the families receive, and so forth. We want to be sure that children with disabilities, under the inclusion principle, are not arbitrarily excluded from any of the evaluation activities. We are examining how appropriate the programs' design approaches are for all cultural groups in the communities that they are serving.

We think of the evaluation as having four key components. The first is the implementation study and the various features of that, documenting all the activities that are going on in each of the four cornerstones, measuring program quality and the intensity of the services in each of the areas. The second component assesses the extent to which programs are achieving a full degree of implementation and evaluates the variation that occurs across the 17 sites, which is a process still under development. The third component describes the programs in a community context as they are developing. The fourth component is the local research.

There are three major research questions. We start with descriptive questions, being sure we understand who the families are, what the staff and communities are like, and so forth. We want to know the pathways to quality, which is part of the implementation study, and develop lessons about how programs go from beginning Early Head Start programs to full implementation. Then there are the important impact questions about outcomes for children, families, communities, and staff. Going beyond that, we want to look at such things as the developmental trajectories and how children and families change over time. There are some important aspects of program variations that we expect, and we are seeing tremendous differences across the different

Head Start Partnerships, Research, Practice, and Policy

programs. The bottom line is providing information that will be useful for program development and for policy at the national level.

We are beginning a process in which the local researchers are working with the local program staff to articulate what the expected outcomes are at each program, and what the expected process for achieving those outcomes is, or what the theories of change are that the different programs have, to help us understand not only what outcomes are most important to measure, but how to plan analyses to understand how those outcomes are achieved. For the parent and family cornerstone, there is a whole range of things: parenting knowledge and attitudes, family functioning, use of services, relationship of service use to family needs, and so forth. We are not neglecting the staff cornerstone, although it is one of the more difficult ones to assess. There is emphasis at the program level on staff development for services for infants and toddlers, for ways of improving the continuity of staffing over time, and for developing relationships between staff and parents. At the community level, using site visits and information from the local programs, we will be able to get a lot of information about the communities. In addition, we are going to conduct what may be one of the largest studies of child care for infants and toddlers in low-income families in this country. Every child in the Early Head Start sample who receives child care through the program or through referral to other community agencies will have their experience in that child care environment assessed and observed directly. Another community goal of Early Head Start is to increase the collaboration among agencies to insure better receipt of services by families and to develop a community of Early Head Start families as well.

We will be conducting various types of analyses. There are overall program impacts, but there is also more sophisticated analyses to look at the extent to which program variations affect outcomes, identify particular subgroups for which programs may have differential effectiveness, such as teen mothers, and the variations in service use and how they contribute to overall outcomes. Finally, there is understanding the developmental trajectories as children and families develop over the course of their experience with Early Head Start. Hopefully, after this particular part of the study is over, ACYF or other agencies will be able to support longitudinal study of the approximately 3,400 children and families that will be involved in this research study.

Helen Raikes: Two Early Head Starts will share information about their program, their partnership, and the research that will be conducted at their site. One program that is a former Head Start, Bear River Head Start, Logan, UT, represents a rural site that delivers home-based services. The other is an urban site that is new to the Head Start community, Educational Alliance, New York City. These two programs are examples of the tapestry of contrasts that exists in the Early Head Start community.

Glenna Markey: Bear River Head Start was in the first group of Head Starts that was funded in 1965. In addition, we have had a number of other Demonstration programs. We were 1 of the 16 Home Start sites, and we also had a Family Service Center. Therefore, we have a long history of being involved in research. Bear River Head Start is located in the northern part of Utah and the southern part of Idaho. We are a rather strange program because we cover two states and two regions (Region VIII and X), made up of seven counties with a total area of 12,000 square miles. It is rural farm country with agriculture-based industry. There are also mountain areas with the Bear River running through all of the counties that we serve. Every county sits in a valley, and in order to get from one valley to another, you have to go through a canyon. This makes travel in the winter extremely difficult. Most of our staff has four-wheel drive vehicles. We are trying to

keep the Early Head Start service radius to about a hundred miles. Logan, UT, is a small community in the geographic middle of the area that we serve. It has a population of about 40,000 people with all of the services that one could need: health, dental, social services, and WIC. It is also the home of Utah State University.

We serve Asian and Latino populations. A large number of the parents work at the E. A. Miller Meat Packing Company or in cheese processing plants. Many others work on farms where farmers hire seasonal workers that were migrant workers who stopped and stayed. The farmers provide them with a home and dairy products such as butter, cheese, milk, and beef, and, therefore, pay them a very low wage. That is the way they live. The predominant two religions are the Mormon Church and the Catholic Church. Both encourage large families, since a large family is economically necessary in order to run the farm. Also, fathers are valued and father interactions with children are culturally important. Family activity is highly prized.

Lori Roggman: Utah State University is a land grant university. That means that as part of their mission, they support applied research. Therefore, there is institutional support for the kind of partnership that we formed, researchers providing service to the community in general, and then doing research that has direct application. My primary research interests have been in infant social development, looking at mother/infant attachment and the development of play early in life in connection to outcomes related to both social and cognitive competence. I am interested in parenting antecedents to those issues. The program had its own interests, which were to have a direct effect on parenting through a home visiting program and also to increase the availability of child care. Bear River Early Head Start will not be providing child care, but will be offering training to family day care providers so we can increase day care availability for infants in those extremely remote areas where there are no centers. When the RFP came out, we began identifying mediators and moderators that were of interest to all of us. That was an important part of forming the partnership—to figure out how the pieces fit together for us as a whole.

Barbara Greenstein: Early Head Start at the Educational Alliance, NYC represents a creative, state-of-the-art model of service delivery that supports and facilitates our positive research partnership. We comprise a consortium from both the public and private sectors. Specifically, the Educational Alliance serves as lead agency in collaboration with the New York City Board of Education; Bellevue and Mt. Sinai Hospitals, which provide on-site medical care; and New York University, our research partners. We serve 75 families in three sites. Two are located in Board of Education high schools and target teen parents, their young children, and extended families. These are located in Brooklyn and in mid-Manhattan. The third site, the largest, which serves community families, is located at the Educational Alliance headquarters on the Lower East Side of Manhattan.

Both the Educational Alliance and New York's Lower East Side share rich and diverse histories. As a settlement house founded 108 years ago, the Educational Alliance's mission was to provide social and educational services for the purposes of resettlement and assimilation to the influx of Eastern European Jews to the Lower East Side in the 1880s and 1890s. The agency was born out of the philanthropic teachings of Judaism, which deemed sacred the act of helping those in need to help themselves. This is a mission we still hold dear. Some of the services that we were providing in the 1890s included nutrition, health care, English lessons, history lessons, and vocational and recreational services. As an example, in the year 1897, 1,000 children and adults per day took English classes at the Educational Alliance. As the demographics of the area

Head Start Partnerships, Research, Practice, and Policy

changed in the post-World War II era, the agency professionalized and moved more in a social work direction. It adopted a sophisticated, multicultural vision. By 1960, the Educational Alliance was serving the most disadvantaged groups, including the mentally ill, high school dropouts, minority mothers and young children, runaways, and the aged Jewish poor.

We have been providing Head Start services for 27 years and day care services for 40 years. We combined the Head Start and day care programs this year and now serve 329 young children and their families. The ethnic breakdown is a heavy concentration of Chinese-American families, since we are right on the edge of Chinatown, along with Latino, Jewish Orthodox, African-American, and Caucasian families. The goals of our program dovetail and flesh out the four cornerstones of Early Head Start. These include promoting positive cognitive, motor, social, and emotional development of young children; insuring the physical and mental health of children and families; fostering good attachment in positive relationships between children and parents; promoting positive parenting of both mothers and fathers; promoting educational and vocational independence for parents; and supporting positive community involvement in family life. We seek to attain these goals through day care for infants and toddlers, home visiting, developmental assessments, parent and family assessments, health and mental health services on site, interactive work with parents and infants, parent groups, vocational training, literacy training, English as a second language, GED, and referral for Part H early intervention.

There are several special qualities of the program. The entire staff is either bicultural or bilingual. The staff speaks Spanish, Mandarin, Cantonese, and American Sign Language. We have recruited five Head Start parents to serve as assistant teachers in the classroom. They are now receiving eight weeks of intensive pre-service training for which they receive a stipend. For a year, they will continue to receive the stipend, serving as our caregivers in the early Head Start classroom. At the end of the year, we will help them become licensed family day care providers, essentially starting a cottage industry in the community, since there is a desperate need for family day care on the Lower East Side. Additionally, this supports the need for continuity of care of babies, because as our parents become independent and move into full employment, the children that these Head Start parents have been caring for all year in the classroom can now move into their homes, as they will be family day care providers. We have on-site medical services. There is an integration of infant mental health and early childhood education services. I am an infant mental health person. The psychologist, social worker, and case managers are college graduates or have master's and Ph.D.s and extensive experience working in clinical settings with infants and toddlers. We are quite multidisciplinary in our approach. Finally, the community is multicultural. This allows us to have an opportunity to examine the cultural differences in families: their values, attitudes towards children and child rearing.

The partnership is going well. We are fortunate that the NYU colleagues share our vision of what a quality program would look like and what we would be interested in studying. The research integrated perfectly into what we already intended to do and were doing programmatically.

Mark Spellmann: We are proud to be the partners of the Educational Alliance. The settlement house tradition is impressive in the history of social work. I will present a sampling of the research that this program affords us the opportunity to conduct and about paths that we intend to assess. We are going to examine the relationships between senior staff and direct-care staff, to see if they are supportive and respectful of different cultural values about raising children. Then we will explore how those paths relate to the mothers. Will mothers perceive staff to be supportive

and respectful of different cultural values around the raising of children? Most middle-class White values center around things like independence, autonomy, and assertiveness. I am not even sure there are words for assertiveness in Spanish. We have to be sure that we offer the respect for different values that mothers may have. Otherwise they are going to turn their children over to the nice White professionals who have the only service in town and sort of give up. Then we are hardly going to get the kind of maternal efficacy, the sense that they can advocate for their children, that we want to foster. We will look at outcomes in the children as a result of these paths of relationship. Do they have a greater sense of competency? Do they form stronger attachments? Are they more socially competent?

We also will examine health and mental health variables in a path model. Stress and exposure to violence are all too common in the population that we serve. These experiences may be less traumatic with support from staff. The support may reduce incidence of post-traumatic stress disorder (PTSD), anxiety, and depression. In a study we are conducting in comparable neighborhoods in New York, we find that 50% of older adolescents suffer from various levels of post-traumatic stress disorder for which people typically seek out-patient treatment. We will assess diadic variables in the mother/infant relationship. We are going to use the *Mahoney Mother-Infant Rating System* to assess these variables. We are exploring whether these qualities of relationship between mother and infant have direct effects on outcomes of social competency, academic competency, and child emotional well-being, or whether they are mediated through attachment.

Teresa Alvarez-Canino: We want to take advantage of the richness of New York City's population and be able to understand the cultures. Recently we began studying some of the values that low-socioeconomic Puerto-Rican mothers held. Generally, cultural groups are partly defined by the values and beliefs shared by their members. Each cultural group considers its beliefs and values as important for the development and conduct of its members. Some of the beliefs and values a group holds may also be held by other groups, yet these may be differently defined and applied in the socialization process. In the domain of child rearing, each cultural group possesses some beliefs about the nature of children and their development. A culture's values and beliefs about the meaning of parental and child behaviors are typically elaborated over long periods of time and within a sociocultural, political, geographic, and historical context. Parents' child-rearing values and beliefs, and how they are operationalized in parenting behaviors, are undergirded by the values of the parents' culture. Parents' ideas about, for example, children's development (i.e., intelligence, social behavior, and school performance) is influenced by the parents' culture, education, and, in the case of immigrants, degree of acculturation. Much of the research on child socialization has been focused on the parental behaviors that influence the child's socioemotional development. In the United States, parental influences on child socialization have been studied primarily in Euro-American samples.

In our study, we want to look at the assumptions Latino mothers and other cultures, like African-American or Chinese-American, use to guide their behaviors with children. Some of the literature has focused on traditional culture or values of Latinos, for example, that have been passed from generation to generation. In short, the behavioral sciences have been identifying some of the behaviors that Latino mothers employ. We know little about what cultural assumptions, beliefs, and cognitions they use to guide their behaviors and, ultimately, what kind of behavior they want their children to demonstrate. We want to answer questions of why these different cultures do what they do in child rearing.

Head Start Partnerships, Research, Practice, and Policy

In the study that we did in New Jersey, we had to develop the instrument, because there was nothing available. We held focus groups with Puerto-Rican Head Start mothers to gather information on what they consider their values and how they define them. For example, we found that independence as defined by the American culture is completely different as defined by the Puerto-Rican culture. After that, we looked at the literature and we gathered information about values held by the American culture, and we put definitions to them. From there we developed an instrument. Interviews were conducted with 80 to 120 mothers. They also participated in focus groups afterwards. We hope to use that same instrument. For other cultures that we might encounter in the Educational Alliance, we are planning to hold focus groups in order to gather from them what their values are. We will help them in determining and defining them. The reason for doing this is that we find that a lot of barriers to service delivery are based in differences in how we see and define values. This is especially true when the agency is not run by the people from the same culture as those they serve.

Robert McCall: I would like to address two themes. One is the model of this research enterprise, and the other is a realistic attitude about what you may expect to find. Those of you who have been around a while and watch national intervention programs implemented will know that they have followed different strategies. With respect to intervention, there are occasions when the government has dictated in excruciating detail what each site must do, down to the number, the type of visits, and so forth, in an attempt to have a uniform single intervention that is carried out at all the sites. On the other hand, sometimes RFPs are vague. They have a general intent, and each site creates their own rather incomparable intervention. What we have here is a compromise between those extremes in which a set of six or so principles were laid. Each is to follow that general concept so defined, but with individual variations and emphases.

The same is true on the evaluation side. Sometimes national programs are evaluated by an outside contractor who does the entire evaluation from some remote location in the United States, trying to supervise data collectors at 28 different sites around the country, none of whom have any relation to the program. In other cases the RFP simply says, "Thou shalt have an evaluation," and it is done individually and, again, noncomparably from site to site. Early Head Start evaluation is a compromise in which there is a national evaluator and a core set of assessments that will be administered at each site. The evaluation enterprise is being carried out by researchers at each site who will supervise, monitor, and collect the national data and in return can include their own assessments at their site, to monitor and evaluate the emphases that they have implemented in their intervention program and that are of interest to them. One hopes that we will have a better, more reliably and conscientiously collected core evaluation on the one hand, and rich interpretive local data collected at each site, to supplement the core, provide feedback to local programs, and enrich the literature.

Let us look at a comparable situation such as the early enrichment studies of 20 years ago. We had a consortium study across all studies with Lazar and Darlington. That was useful in pointing out general themes, general effectiveness, and an inference at the time that it was parent involvement that made the difference. They blurred their eyes across these studies and said what might be a mediator, and they inferred parent involvement. Almost every substantial intervention since that time has used parent involvement, despite the fact that we have never manipulated parent involvement to know if it is crucial or not, but we all suspect that it is. On the other hand, what do individual studies have to contribute? Who would deny that the Perry Preschool Project, as an individual study, despite the presence of that consortium, has contributed as much to early

Head Start Partnerships, Research, Practice, and Policy

childhood development scientifically and from an advocacy standpoint as the whole set of studies? Therefore, there is a rich opportunity for both the national evaluation and these individual studies.

The second theme that I would like to talk about is realistic expectations about what we should expect from the data. I raise this issue because Head Start itself has been a victim of its own eagerness, where great expectations were pronounced and were not fulfilled, at least not in the promised form. Then the policymakers said it did not achieve what you expected it to, and, therefore, we are going to cancel it. Fortunately, we are still here, but some of us older people remember several crises in the past in which that outcome was uncertain. We need realistic expectations.

This study is only looking at children to age three, so far. We are hoping that this is Phase I. In large part, process may be the most important outcome of this endeavor in several areas. First is the process of service providers getting their programs together in the first three years. Those of us who attended the session on the University of Texas at Arlington project saw a vivid demonstration of how it took three years of experienced service providers before they had an efficient enough program to make a difference for children. Next is the process of families developing a relationship with the program. There are several more anecdotal reports from family support programs that the most important thing that transpires in the first several years is the family developing a sense of trust and confidence in the program. That will not happen without relationship. Third is the process of researchers getting together with the program. Some people think that the university/Head Start/community collaborations that are involved here may be the seeds of the most enduring consequences of this project. This is not a process of researchers getting together among themselves.

I suspect that we are not going to see a great many significant outcomes for children in the first three years, not as much as we would like to see. The most important outcomes may be on the parents in the first three years, and those may not be the political "hot stuff." Parents may be involved in educational opportunities and job training, and may be receiving more, not fewer, services, and therefore appear less psychologically and economically self-sufficient until those intervening processes bear fruit. Similarly, they may have more self-confidence and more self-efficacy on questionnaires, but may not have achieved most of their goals yet.

We all feel that this is a rich opportunity for these 15 sites. It is a unique approach, and we want to take maximum advantage of that. With every opportunity, however, comes a responsibility. In my 30 years in this business, I have seen the government and private philanthropy invest fairly large sums of money in different projects. Sometimes they were projects that were implemented by a single individual or one or two institutions. Sometimes those individuals or institutions did not make the most of that opportunity and did not perform well. We no longer have those funding programs and those opportunities. We 15 sites feel strongly that we have a corporate responsibility to science and to the intervention community for the trust that has been invested in us, and also a responsibility to both the children and families that we are trying to serve today, as well as those that may come in succeeding generations.

Kathryn Barnard: In many ways, all of us who are involved in the research effort feel fortunate to have this opportunity, but, at the same time, we realize how unprepared we are in terms of our experience and training to deal with the challenge of producing findings that will be helpful to the American public and to children and families. Few of us were trained in how to detect experimental differences with planned program variation, and also many of us were not trained

Head Start Partnerships, Research, Practice, and Policy

on how to measure moving targets. Built into the design is the variation that Head Start has been famous for, letting local programs explore their individual belief systems in what they do. Also, there is the continuous improvement plan that was part of what the Advisory Committee felt was important; that is, that data that are collected should be fed back to programs to help them improve.

In thinking about the cornerstones that we are building and measuring in this project, one cornerstone is the community. In tracking the program that I am associated with, they markedly changed the environment for all children in their former CCD program by bringing together over 30 agencies in the community to focus on the issues of children and families. We now have many programs in these communities, and we are even beginning to see a reduction in the reporting of child abuse and neglect. We are collecting subjects who are randomized into Early Head Start and into the control group, but the children that are in the control group are in a different community than they were five years ago. How much more is that community going to change to embrace the needs of children and families? It is a real challenge.

I would also support Bob's idea that developmental outcomes or status may be the last information that we find. First, we may learn more about process and pathways. That is why the interactive engagement of the Head Start programs and the university researchers is an important endeavor at this time, in order to present their best ideas of what their theories of change are, what they are trying to target, and what they expect to happen. We will be looking at that in a continuous way because those theories will change over time as the dialogue goes on between the researchers and the Head Start program staff. Communities change; families change. We have the possibility of active welfare reform right in the midst of what we are doing, where it looks as if women will be expected to get off welfare and go back to work much sooner than ever before. That is certainly a dynamic that will affect this. Staffing, in terms of the mixture of people who are involved in these programs, is likely to change over time as the economic situation in the communities changes. For instance, in my community the level of pay for the people that do the home visiting program is marginal compared with other employment opportunities that are available. How is that going to affect the people that are part of the program?

In relation to the child, what kinds of goals do we have for children in our society? Do we want them to be "normal"? Do we want them to be in one standard deviation of the mean on this test or that test? Do we want children to be enriched so that their individual differences are something that we are interested in promoting? Do we want compensation for children who have disabilities or chronic health or physical problems? What are our goals? How does the design of our research take that into account? What are the protective mechanisms that we can help children and families develop? How can we help people learn how to cope with their life situation? When children from high-risk populations and samples begin to get in trouble, the first thing that you see begin to slip is their communication and language skills. How do we track this process, and would it be better to look at the evolving processes of communication-coping, their ability to have relationships at this early age, rather than looking at developmental outcomes? We are caught in a paradigm shift, and probably none of us would be satisfied unless we had those developmental markers. However, I do not think those standard developmental markers are going to provide much of a contribution to the particular findings and the knowledge that we gain from this study. It is in some of the active processes of mechanisms of protection that we probably are going to better understand the ways in which communities and programs assist families in meeting their goals.

BEST COPY AVAILABLE

I was thinking about Bear River and what kind of outcomes I would want there. What kind of coping mechanisms or what kind of communication patterns I would want to help children in that community develop. Are those children going to stay in Bear River? We need to begin to think of the specificity of environment/person interaction and how that creates a better adaptive person in the future, rather than the generalized model that we have all been using to understand development and behavior. The national study is an important backdrop, but the pathways are going to be more explicitly found in looking at the local research questions and how particular issues that Head Start programs and local researchers are trying to address are demonstrated in the outcomes.

Audience Questions and Comments

Question: Is spanking an issue with the caregivers in the Early Head Start program?

Barabara Greenstein: The caregivers that we have recruited are multicultural. They are Head Start parents who receive intensive pre-service training. One of the things we wanted was for even the application process to be a potential learning experience. I posted the position, received résumés, and conducted interviews and second interviews. In that way, even those parents who were not selected had a taste of what it was like to have an interview. During the interviewing process, we asked questions that got at their attitudes about children, what they knew about infants, and differences among infants, toddlers, and the Head Start population. One of the questions that I asked was, "Since we know that there are so many different kinds of people that live in our community, what would you do if one of the parents of a child that you were taking care of said, 'My 13 month old really likes to climb and I don't want him to climb, and if he does, you can spank him?'" I do not know if this was censored because I was an outsider, or if it reflects the self-selection of parents who volunteered, but everyone said, "Oh no. I would never do that." We got a sense that in the population we are working with, everyone knows hitting a child is not a good thing to do. Whether some people impulsively do it anyway because of characterological issues is another story, but as a value system, everyone seems to be against it. We would always reinforce their response by saying, "That is right; we feel the same way. Nobody hits children in this program."

When we asked parents what they would do, it was not just "Would you hit or not, but how would you handle it?" Many of the better answers had to do with speaking with the parent and letting them know that we did not think that this was useful to the child, and that, in fact, it was simply a rule. We tried in our training to make that distinction. Some things are rules and that is it, but for the most part we would go along with someone's cultural bias and hope that through education we could build a different attitude. As an example of that, in our teen-parent site, one of our caregivers is a man. The girls said they do not want him changing their babies' diapers. At first we thought, "He is their primary caregiver, who else is going to want to do it?" It presented some logistical problems; however, we realized this was something we were going to have to respect at the beginning and work towards the young mothers trusting him. We were quite sure that things would "mellow out" and change, and for the most part they did. It is still a new program, however, and we continue to be in flux about that.

Head Start Partnerships, Research, Practice, and Policy

Helen Raikes: We appreciate you putting your finger on some of the cultural and values issues that are particularly keen as we are looking at this new population in Head Start. We are struggling to be sensitive to cultural issues of measurement and purposes of program. Early Head Start, both on the programmatic side and the research side, is keenly focused on program quality and on how we use research to attain program quality. We may not be coming through the formality of the QRCs as the mechanism for doing that, but there is an intense Training and Technical Assistance (T and TA) effort associated with Early Head Start. There is coordination among the T and TA staff, the research team, and the program staffs all working collaboratively on a daily or weekly basis. The concept of continuous improvement is a new expectation that was inserted into the Early Head Start RFP. It is something we are all working together to understand. We want to discover the routes of formative evaluation that will help programs learn about their own outcomes so that they can more speedily attain their own goals.

Early Head Start is being coordinated through Zero to Three at the National Center for Clinical Infant Programs. Helen Keith is directing that T and TA effort, and they have a subcontract to Education West, which is Ron Lally's organization. We have some excellent infant/toddler people working with us and developing the T and TA for Early Head Start. In addition, in the great diversity of Early Head Start, some programs have on-site child care. That is part of their child development cornerstone approach. Some programs will refer families who need child care to child care in the community. They need to do something to insure that the community child care programs are of high quality. If they are offering child care on site, we would expect some intense training on child care quality.

Comment: If one suggests that there may not be profound effects on children at age three from this intervention, then why do this? The answer is that a number of other things that are happening may contribute to even more positive outcomes later. One is the engagement of the parent and the functioning of the parent as a parent and as an intervener in subsequent years. The other is a realistic expectancy that the effects may not be profound on the children at age three, but that this investment will pay dividends in the children and families later.

■ Head Start Correlate Studies

Chair: Daryl Greenfield

Presenters: David Dickinson, Matthew J. Taylor, Donna Bryant, Daryl Greenfield, Marianne Chalkley, Mary Lou de Leon Siantz, Susan Churchill

The presenters in this invited poster symposium were a group of researchers who were funded from 1991-1992 by the Head Start Bureau's parent agency (Administration for Children and Families) under a request for proposals (RFP) entitled "Correlates of Positive Outcomes for Different Types of Head Start Children and Families." This RFP was a response to much of the earlier longitudinal research that compared children who attended Head Start with low-income children who did not attend Head Start. These earlier studies treated Head Start as a monolithic program and Head Start children and families as a homogeneous population.

One of Head Start's significant features, however, is its enormous variability. Head Start varies from community to community in the way program services are delivered, the makeup of the populations being served, and the local conditions that exist in the community in which Head Start operates. The correlates RFP provided funding for researchers to explore this variability. As stated in the RFP, "Head Start is embarking on a new generation of research which examines such questions as 'What works best for children and families with different characteristics under what conditions?' and 'What program, family, and community variables foster positive effects in Head Start and future years?'"

Projects were submitted and reviewed in a national competition to determine funding. Each investigator was free to choose any hypotheses and major study variables that investigated correlates of positive outcomes for different types of Head Start children and families. As the titles of the individual papers in the poster symposium indicate, the projects that were funded vary considerably in focus.

The Impact of Variation in Preschool Experience on Children's Language and Literacy Development David K. Dickinson, Miriam W. Smith

The Home-School Study of Language and Literacy Development is a longitudinal study investigating the factors that support low-income children's literacy development. We hypothesized that decontextualized language skills (i.e., skill in using and understanding language that communicates meaning primarily through words and syntax rather than reliance on gestures, intonation, and contextual clues) are critical to children's reading comprehension abilities in later elementary school. We also hypothesized that support for language development in the preschool years plays a major role in supporting later literacy skills. To test this hypothesis, we have followed the language and literacy development of a group of children from low-income homes since they were three years old. Children were visited at home and in school. This paper reports data from their preschool classrooms.

Classrooms were visited once each year from the time when our target children were age three to when they attended second grade. Each year, we made classroom observations and interviewed teachers about their approach to teaching and their perceptions of our target children. When children were in preschool, we audiotaped the child's and the teacher's spontaneous conversations. Teacher tapes were transcribed, coded, and analyzed using CHILDES software to determine the frequency of rare word use. Child tapes were coded directly from the audiotapes for the amount of time a type of talk occurred, setting, and conversational partners.

Head Start Partnerships, Research, Practice, and Policy

Beginning in kindergarten, children were administered annual batteries of tests of language and literacy development. The kindergarten battery included a broad-range test of emergent literacy development, the Peabody Picture Vocabulary Test (PPVT), and tests of story telling and story understanding. In first and second grades, children were given the decoding portion of the WRAT, the Gray Oral reading test, and a story production test. In second grade, children were given the PPVT.

Regression analyses were conducted using preschool variables that reflected naturally occurring variability in program quality to predict subsequent language and literacy functioning. Two classroom variables from the time when children were age three were predictive of later performance: percent of time children engaged in verbal pretending and percent of time teachers reported spending in small group activities. A wider range of experiences at age four was predictive of later outcomes: child use of decontextualized talk (including pretending), time spent in small group activities, the amount of teacher use of rare vocabulary during meal times with children, and the presence of a rich curriculum. Regression models using preschool variables were predictive of story production from kindergarten through grade two; story and listening comprehension in kindergarten and grade one; vocabulary in kindergarten and grade two; and oral reading in first and second grades.

These results indicate that differences in the quality of experiences when children are in preschool have long-lasting impacts on children's later language and literacy development. In particular, they suggest that 1) children's spontaneous pretending and decontextualized talk should be fostered and encouraged during the preschool years; 2) rich curriculum and time devoted to small group activities are powerful experiences that relate to subsequent outcomes; and 3) teachers should look for natural ways to incorporate rare vocabulary in their daily interactions with children.

Head Start Success Study: Archetypes and Preliminary Causal Model

Matthew J. Taylor, Mark S. Innocenti

The Head Start Success Study is a longitudinal, nonexperimental project designed to determine how Head Start intervention can be strengthened to meet the needs of the children and families being served by Head Start. This study is one of the Head Start-focused longitudinal research projects being funded by the Administration for Children, Youth and Families of the Department of Health and Human Services. Over a five-year period, this study will follow 248 Head Start children and their families, enrolled in three cohorts across successive years, through first grade and into third grade (for the first cohort). The project is being conducted in collaboration with the Head Start grantees and local education agencies in Salt Lake City, UT. Extensive information is being collected on child, school, maternal, and family variables. The study is focused on identifying relationships among variables that address the larger questions of "What works best for whom?" and "What variables are associated with initial and continued success?"

Descriptive data obtained for the sample during the Head Start year is presented. Although not all descriptive data can be presented in this summary, interesting findings include the following: child cognitive skills and school readiness skills are low when children enter Head Start and remain relatively low upon exit (26%-37% and 21%-22%, respectively); children score high in classroom problem behaviors (97%) and low (30th percentile range) on various social skills measures; children's temperament is characterized by low distractibility and low persistence (32% and 25%); and families are high in stress and low in resources (79% and 28%).

Two models are presented. The first model examines the relationship among family functioning, maternal variables, parenting behaviors, and child cognition. Correlational analyses suggest a sequence of relationships. The second model examines the relationship between maternal personality, home environment, and child social skills. Correlational analyses again suggest a sequential relationship. A path analysis demonstrates a relationship between maternal personality and the home environment. A bicausal relationship was not found between the home learning environment and child social skills. The model implied causation from the home to the child's social skills, but not the reverse.

The second technique discussed was archetypal analysis. This relatively new approach allows non-normally distributed data to be interpreted in archetypes that best represent the data. Archetypal analysis was applied to maternal and child cognitive data and to maternal parenting expectation data. Archetypes were identified and correlated. The technique is still in an early phase of use. Some issues to be considered in further analyses with these types of data were discussed.

Effects of Home and Classroom Quality on Cognitive and Social Outcomes of Head Start Children *Donna Bryant, Lisa Lau*

This study examined relationships between classroom quality, home environment quality, and child outcomes among 281 Head Start children who attended one of 47 Head Start classes. About half of the classes were located within a small city and about half in rural areas. The sample was primarily (85%) African American. Classroom observations and parent interviews were conducted in the winter and spring of the Head Start year. Child assessments and teacher ratings were collected near the end of the year. Children were tracked into kindergarten in a four-county area. At the end of kindergarten, teachers completed two rating scales, and a project researcher abstracted information from the school records. Follow-up of the children will continue until third grade.

Measures included the Early Childhood Environment Rating Scale collected during the Head Start year, the Home Screening Questionnaire from the parent interview, and several measures of the child near the end of the Head Start year: the Preschool Inventory, Kaufman Assessment Battery for Children, Vineland Adaptive Behavior Scales-Communication, and the Adaptive Social Behavior Inventory. The latter two are teacher ratings. The children's kindergarten teachers completed two ratings scales of social and language skills, the Classroom Behavior Inventory and the Vineland Adaptive Behavior Scales-Communication. Data were also obtained from school records.

Results showed that the stimulating characteristics of both home and classroom environments significantly affect the cognitive outcomes but not the social outcomes of Head Start children at the end of their Head Start year. Children's communication abilities were strongly influenced by home environment quality, but not by overall classroom quality, perhaps because language stimulation was one of the weakest domains in the classrooms. In general, the Head Start classes were not of high quality. Continued training, support, and encouragement are needed, particularly in the area of language activities. No classroom received a mean rating of less than 3.5 on the ECERS, indicating that the current standards and training are at least sufficient to prevent the inadequate care often seen in preschools in this state.

A high proportion of the home environments of the children were rated poorly on the HSQ. Helping parents improve the quality of the home learning environment continues to be a chal-

Head Start Partnerships, Research, Practice, and Policy

lenge for Head Start (and all early childhood programs). In kindergarten, 44 percent of the Head Start children missed more than two weeks of school, and 6 percent were retained in kindergarten. Although the mean Vineland Communication was 83 percent, many children were doing well in kindergarten. We hope to follow these children until third grade.

Positive versus Negative Elementary School Outcome for Head Start Children: The "Fade-Out" Effect Revisited *Daryl B. Greenfield*

Certain research questions can only be addressed by studying the same individuals over time. Traditional longitudinal studies, as highlighted in this symposium, are one common approach. Longitudinal studies, however, have drawbacks (e.g., subject attrition, cost, large time commitment) and rarely can support large sample sizes unless the costs are enormous.

An alternate approach to studying individuals over time involves database linkage studies. In this approach, existing data from different database sources are linked, and then analyzed to address particular research questions. This approach is not without its drawbacks (possible sample bias, accuracy of data, missing data, need for complex computer programs), but can provide longitudinal data with large sample sizes at a fraction of the cost of traditional longitudinal studies.

Database linkage techniques were used to revisit the "fade-out" effect with contemporary cohorts of Head Start children. An ambitious project that used meta-analysis to review over 1,600 documents involving prior Head Start evaluation research (*The Impact of Head Start on Children, Families and Communities: Final Report of the Head Start Evaluation, Synthesis and Utilization*) clearly demonstrated the positive immediate effect of Head Start, both on cognitive and social development. However, meta-analysis of the longitudinal studies shows that these effects "fade-out" by third or fourth grade.

Despite general acceptance, the "fade-out" effect, in reality, is based on a paucity of longitudinal data using Head Start samples. In addition, Gamble and Zigler have argued that the methodology used in selecting studies for the meta-analysis has compromised the conclusions drawn in the Synthesis Project concerning long-term outcomes. Finally, the small number of longitudinal studies upon which the fade-out effect is based involved children and families receiving Head Start services nearly 30 years ago. Even more recently published longitudinal work is based on these early samples. Lee and her colleagues analyzed kindergarten and first-grade outcomes of children participating in Head Start in 1969. Their explanation for choosing this sample was that "We are forced to impute the effectiveness of current Head Start programs from a rather dated sample. Why? There are literally no studies of such quality currently available." Evaluation of Head Start based on dated samples is problematic, as everyone recognizes that Head Start serves a very different society and population today than it did in the 1960s.

The present paper used database linkage studies to address the Head Start "fade-out" effect by linking data from three cohorts of children who graduated from Head Start from 1989-1991 with public school achievement data obtained from the 1990-1995 school year records (kindergarten through third grade). These children attended Head Start and public school in a large, multiethnic urban community. Results from this study clearly show that the Head Start "fade-out" effect is an oversimplification and does not represent the diversity of achievement pathways taken by former Head Start children.

Findings from the Longitudinal Head Start Family Impact Project: Implications for Research, Practice, and Policy *Robert K. Leik, Marianne Chalkley*

The Head Start Family Impact Project began as a 1-year intervention and evaluation program that has subsequently been extended into a 10-year longitudinal study of 190 families. Over the course of the project, it became evident that serious decline in support for families living in poverty has been associated with significant increases in family life stress. Furthermore, the interrelations among the family, as well as maternal and child variables, vary significantly as a function of the self-nominated racial/cultural context of the families.

As the initial project expanded, new questions have emerged. These include 1) how to assess appropriately the impact of intervention when families are living under conditions of escalating stress; 2) whether and when stability rather than change might be a desirable outcome; 3) how to examine outcomes in light of the values and context of those receiving services; and 4) how to understand processes involving over-time effects that are often complex and subtle yet potentially very important. Our data and analyses speak to each of these questions. Complete details are available in separate papers. A brief overview of the issues follows.

1. The question of how to judge program effectiveness when something like stress interferes with program goals has generated new issues. Stress often has a complex impact on functioning; sometimes the principal effect is on the interrelations among other variables, and frequently that effect is curvilinear. These characteristics complicate analyzing and controlling the impact of nonprogram factors such as increased stress. Furthermore, appropriate statistical control of factors such as stress can reveal intervention effects that otherwise might go undetected or underestimated.
2. It is often the case that researchers, policymakers, and others assume that an increase on some measure is a sign of improvement. However, there may be situations when stability or decrease might be the desired outcome. Which is preferable may well vary from case to case. Failure to evaluate the direction of change and the desirability of current or subsequent levels of functioning may cause potential program benefits to be overlooked.
3. Considering the nature of change leads to asking whose standards should be used in evaluating any particular level or type of functioning. Desirable levels of functioning are not necessarily those adopted by White, middle-class society. Important cultural differences argue for evaluating outcomes in participant terms.
4. Longitudinal effects often involve complex pathways. Examination of two important characteristics of maternal functioning (mothers' evaluation of the child and maternal depressive symptoms) reveals effects that are not only influential over time but are also mediated via other aspects of family, parent, and culture.

Only with this more enriched perspective can one talk intelligently about the real consequences of participating in a program like Head Start. Our findings suggest that it may be possible to achieve positive individual outcomes without having to customize programs. A focus on understanding underlying processes and how they evolve in nested, complex contexts enables identifying ways to optimize the potential of programs such as Head Start.

Parental Functioning and Child Outcomes among Migrant Head Start Families

Mary Lou de Leon Siantz, Connie Cabrera

Parents have long been recognized as important to the success of the Head Start program. Through its parent involvement, the program is thought to have its most enduring effects. The Parent Involvement component has multiple goals that include supporting parents' personal development and positive parenting. Understanding the factors that promote positive parental functioning among parents may help guide Migrant Head Start strategies for better serving and involving parents.

The purpose of this study was to examine correlates of parental mental health and parenting style in a sample of Mexican-American migrant farmworker parents. Four hundred migrant parents were interviewed. Parental interviews concerned demographic information, psychological state (mastery, self esteem, depression), family stress, social support, and parenting style.

The birthplace of the majority of fathers (72.4%) and mothers (69%) was Mexico. Fathers averaged 19.5 years in the United States, while mothers averaged 19.07 years. Language spoken was mostly Spanish. With respect to acculturation, both parents reported being more traditional, with 59 percent of the mothers stating that they were traditional Mexicans and 36.4 percent reporting being more Mexican American. Fathers reported that they were also more traditional (62.6%), with 30 percent reporting they were more Mexican American. Both parents averaged eight years of education.

Parents reported a wide range of risk for depression as measured by the Center for Epidemiologic Scale (CES-D), with mothers at higher risk than fathers. With a score of 16 indicating depression, the mean score for mothers was 20.94 and for fathers was 17.39. Warm and accepting parenting, as measured by the Parental Acceptance/Rejection Questionnaire, was reported by both parents.

Regression analysis revealed that a sense of mastery accounted for a significant amount of the variance in parental depression and parenting style. Sense of mastery included feelings of internal or external control over one's life. Mothers reported more external control, while fathers described more internal control. Acculturation and gender were thought to be related to traditional family roles. While traditional Mexican fathers make decisions that affect mothers, fathers are affected by external factors like the harvest season, crops, and weather, which affect their employment opportunities as migrant farmworkers. When mothers and fathers felt more in control of their lives, they were less likely to be depressed and more likely to have a positive parenting style. Sense of mastery generated an overall Multiple R of .60.

Based on the findings of this study and earlier migrant studies, it can be concluded that these parents are traditional Mexican, warm and accepting parents who are at high risk for depression. Parents have an important role in mediating the effects of stress and poverty for their children. Therefore, it is crucial for the Migrant Head Start program, through their mental health component, to identify mothers and fathers who are most at risk for depression, and provide them with culturally sensitive, emotional support for their mental health well-being and parenting responsibilities. Such interventions will not only directly help parents, but indirectly prevent or alleviate risk among their children.

Families with and without Multiple Children Attending Head Start

Susan L. Churchill, Zolinda Stoneman, Gene H. Brody

Paper summary not available

■ The Design of a National Longitudinal Study of Head Start Children

Chair/Discussant: Jerry West

Presenters: Elvira Germino Hausken, DeeAnn Wright, Steven Ingels, Samuel Meisels, John Love

Jerry West: I am the Project Officer for the Early Childhood Longitudinal Study. We are going to focus on the national longitudinal study of Head Start children, which is part of the larger study, Early Childhood Longitudinal Study (ECLS). I will begin with a brief overview of the ECLS and a history of how Head Start became involved in this activity with the Department of Education. John Love, from Mathematica Policy Research, will present research issues and questions that the data from the Head Start component of the ECLS will be able to address. Steven Ingels, Project Director at National Opinion Research Center (NORC), will talk about the Head Start component and the various field test activities that will be conducted in late 1996. Sam Meisels, University of Michigan, will give an overview of the assessment battery involving direct and indirect assessments of young children. DeeAnn Wright and Elvie Germino Hausken of the National Center for Education Statistics will be talking about the instruments designed to capture information on the various contexts in which children's learning and development take place that are being field tested.

In the early 1990s, the National Center for Education Statistics began to explore the need for a study of young children as they move into the school system and through the early elementary grades. As we were looking at both the need for that type of data and the various activities that were going on in other agencies, we came into contact with many individuals and organizations who also had an interest in national data on young children as they move into and through school. One early contact was with Esther Kresh of the Head Start Bureau, who was involved in evaluating Head Start research done up to that point and establishing a future Head Start research agenda. We spoke to one of Head Start's research advisory groups, and they approached the National Center for Education Statistics with a proposal to become involved in the Early Childhood Longitudinal Study and to fund a Head Start component of that study.

The Early Childhood Longitudinal Study is being designed and data will be collected with three major products in mind: 1) descriptive and analytic data nationally describing children's status at their entry into school; 2) a range of information about the types of activities that children are engaged in during kindergarten; and 3) children's experiences and growth through fifth grade. In this longitudinal study, we will be collecting data at the beginning of children's entry into kindergarten and annually thereafter.

The basic research issues that the study is being designed to address are 1) transition into school, from kindergarten to first grade, first grade and beyond; 2) the relationship between kindergarten experiences and later school performance; and 3) children's development and progress in cognitive and noncognitive domains. Time and effort are being put into developing instruments to measure cognitive growth. The child is the unit of analysis in all data collections and in the way we thought about and conceptualized the study. We are collecting information on the various environments that influence the child, with a heavy emphasis on family variables (e.g., family participation), school variables, (e.g., teacher, classroom), and various community and neighborhood influences.

The design of the study is a National Probability Sample of 23,000 children from about 1,000 kindergarten programs at 1,000 schools, both public and private, located across the country. In addition to public kindergarten programs, we will be over-sampling private schools or private kindergarten programs so that a separate analysis of these programs can be done. Finally, there

Head Start Partnerships, Research, Practice, and Policy

will be an over-sampling of Latino and Asian children to also support individual analyses. There will be approximately 2,000 to 3,000 Latino, Asian, and African-American children in the sample. Also, we are exploring the possibility of over-sampling Native American children, both on and off reservations.

John Love: To date, there has been no longitudinal study of Head Start based on a national sample. Rather, there have been many strong Head Start studies, many studies of Head Start demonstration programs, and studies of selected Head Start programs in different locations around the country. I will summarize the design of the Head Start Longitudinal Study, review some of the policy issues that concern the Head Start Bureau, or that we think they are concerned about (an ongoing process of working with the ACYF regional and local Head Start staff and parents to make sure that we are addressing the issues that are of interest to Head Start), and then give some examples of the kinds of research questions that the design will be able to address.

The first thing that is important to recognize is that this Head Start Longitudinal Study is embedded in the Early Childhood Longitudinal Study, which places some restrictions on it. A Head Start Longitudinal Study per se might have somewhat different features. When the 23,000 children enter the 1,000 kindergartens that were just described, with the national representative sample that NCES and NORC are able to achieve, we plan to interview the parents at the very beginning of kindergarten and identify all those children who had been in Head Start the previous year. Next we will contact Head Start directors and verify that the child really did attend Head Start. Perhaps we also can get some data on their attendance to be sure that they had some "treatment" before entering kindergarten. This is an important step. Some parents whose children have been in day care and preschool programs of all kinds might say that they were in Head Start when they really were not. This verification is a very important step in the Head Start Longitudinal Study. The Head Start sample in the study will be substantial, even though it is just a portion of the total 23,000 children. We expect to identify approximately 2,100 to 2,200 kindergarten children distributed throughout the country.

The Head Start Bureau is currently thinking about four critical issues: 1) quality of the Head Start program; 2) enhancing school readiness; 3) transition to kindergarten; and, most critical, 4) understanding more about the kinds of outcomes, achievements, and changes in children and families that occur while they are in school following their Head Start experience. The first of these issues cannot be addressed in the Head Start Longitudinal Study. Since we do not identify the children until they enter kindergarten, we do not have any information about the quality of their Head Start experience. We decided that the retrospective data we could obtain might be misleading or inaccurate. In addition, there would be no baseline data on children's levels of ability, sociability, and so forth. We recognized at the outset that this is one set of questions that will not be addressed in the Head Start Longitudinal Study. However, there are three other important questions that we can address.

There are two major issues bound up in the concept of readiness, or debates about readiness. The first is the nature of the concept itself, and the second is the attributes of children's development and learning that the idea of readiness tries to encompass. The difficulty with the concept is that readiness cannot be defined in isolation of the context in which children's abilities are able to be demonstrated. If you do not know what kind of kindergarten classroom a child is entering, it is impossible to say whether or not that child is ready. Both the Goal One Technical Planning Group and the National Association of Elementary School Principals have emphasized that if we are going to deal with the issue of readiness, we have to know more about the condi-

Head Start Partnerships, Research, Practice, and Policy

tions in the schools that children are getting ready to enter. I think one of the real strengths of this study is that by merging the Head Start study with the ECLS, we have the possibility of collecting extensive data on the schools the Head Start children enter.

The other concept related to readiness is the importance of understanding how families and communities contribute to children's development and help them be successful in school. We expect to have extensive information about the families and the communities of all the children in the ECLS sample, including the Head Start children, which will enable us to understand more about these contributions to readiness.

We spent time thinking about the five dimensions of learning and development that the Goal One Technical Planning Group identified and have data pertaining to all of those dimensions. We are able to describe what those profiles look like as Head Start children enter kindergarten. We can look at their relative strengths and weaknesses across those dimensions and can learn about what the kindergarten teachers are doing, what their classrooms look like, what classroom practices are like, and so on. In addition to our objective measurements of a child's development and learning, we also will see whether, from the perspective of kindergarten teachers, the Head Start children are thought to be ready for school. Also, from parent interviews, we will be able to look at a relationship between parents' expectations and children's performance in kindergarten and in the later grades.

Adjustment to kindergarten can be particularly difficult for children who enter more academically oriented or teacher-directed kindergartens from the more developmental Head Start preschool. Because we have a national sample of former Head Start children at kindergarten entry, the Head Start Longitudinal Study will be able to collect data on a number of such issues related to transition. For example, there is very little empirical data on the effects of the continuity or discontinuity between Head Start and kindergarten on children's later success in school. With extensive data on the teaching practices in kindergartens, we can relate them to what we know about the teaching practices in Head Start classrooms. We can ask teachers, school administrators, and parents about the kind of coordination there was between the Head Start program the child attended and the school before the child entered kindergarten. We want to know the kind of activity the school conducted to help smooth that transition into kindergarten. This will help build on some of the variables that are being looked at in the Head Start demonstration that is evaluating transition programs. From the parent interview, we can find out what the parents have done to help the children with the transition.

Another area we can address is the important one of learning more about the school experiences children have after leaving Head Start. Even though we do not have baseline data on Head Start children, it will help us understand some of the possible reasons for the so-called "fade-out effect" of Head Start. We are going to know a lot about the experiences children have not only in kindergarten, but also in first, second, third, fourth, and fifth grade; how those experiences change; what kind of continuity there is over time; and whether Head Start children have different experiences than other children in the ECLS sample who did not have Head Start. Valerie Lee found that the schools former Head Start children went into were lower in quality than the schools of non-Head Start children. That study had some problems because it retrospectively asked about the Head Start experience. In our sample, we will know for sure which children had Head Start experience, and also the quality of their elementary school experiences.

We also want to find out about the contexts of the Head Start child's school experience; for example, the socioeconomic mix or the ability mix of the classroom he/she is in, the different

Head Start Partnerships, Research, Practice, and Policy

kinds of schooling practices that might make a difference as children progress through the grades, information on grade retention, and so on.

In summary, data from the Head Start component of the Early Childhood Longitudinal Study can help us understand policy issues related to enhancing readiness, fostering continuity through attention to the preschool/ kindergarten transition activities, and learning more about children's experiences once they get to school.

Steven Ingels: My focus is the field test, involving about 2,800 kindergarten and first-grade students. This study has a parent survey that should have 100% of the parents participating. We will ask about experience prior to kindergarten, which would include Head Start. To verify that Head Start experience, we want to build some of the methodological inquiries into the field test.

A major issue is that of sampling. We know that the main study will have a fairly substantial number of students with Head Start experience—over 2,000. At the same time there are some relatively efficient and cost-effective ways to increase that sample size by doing a within-school over-sampling. Since we are already going to be in these schools, we could devise a method of identifying other students not selected in the sample who have Head Start experience.

The purposes of the Head Start component within the ECLS field test are 1) to test procedures for identifying all kindergarten children selected for the core sample who had attended a Head Start program in the year preceding kindergarten entry; 2) to test procedures for identifying and contacting the Head Start program so that each Head Start child who had attended can be verified in terms of that attendance; 3) to explore the feasibility of over-sampling Head Start participants to increase their numbers within ECLS, determining the best ways of accomplishing this kind of over-sampling, and to assess the costs of the various over-sampling options; and 4) to make some formal recommendations concerning those options, both in terms of sample sizes that are available and the costs that would be incurred for pursuing larger samples. It will be especially important to look at that sample in terms of its efficiencies relative to its cost and to the specific Head Start research questions that could be answered with a larger sample.

The field test will be conducted in approximately 50 schools that have kindergartens. It is not going to be a nationally representative sample, but it is one that is keyed to the requirements of sociodemographic heterogeneity. We are going to make sure that the sample properly reflects different regions of the country, that it reflects public and private schools, that it has urban, suburban, and rural schools represented, and that policy-relevant subpopulations (especially minorities such as African Americans and Latinos) are present in ample numbers for our analytic purposes. About 30 kindergarten children in each of those schools will be sampled. We expect to obtain about 1,400 test observations from these children, parent reports for a subsample of them, and teacher reports for all of them. Given the composition of this sample, we would expect to have about 168 Head Start children falling naturally into that field-test sample, and through over-sampling we probably could increase that to over 300.

The data collection for the field test components is basically structured in the same way as the main study—fall and spring data-collection points. For direct student assessment there will be three components: mathematical thinking; literacy and reading; and general knowledge, primarily topics in social studies and science. There will be a parent survey to gather home background information and to get additional assessment data—primarily socioemotional ratings of the child. There will be a teacher survey that is intended to look at teacher practices and characteristics, and to provide direct cognitive and socioemotional ratings of the child. In addition, in the late spring

at the end of the school year, we will obtain various kinds of archival data from school records. In the fall, there also will be a questionnaire directed to the school principal.

For issues of verification and over-sampling, we are going to look at identifying Head Start children in three different ways. First, we will determine to what degree kindergartens can give us information about who, in fact, did attend Head Start the year before. We expect significant under-reporting from this source. Second, we will find out from parents at the time of the parent interview about their child's participation in Head Start. We expect some amount of over-reporting from this source. Third, within a subset of these schools, we are using a records-matching approach—comparing rosters from Head Start centers within the school's catchment area to the school kindergarten records. If a report says that a child attended Head Start, there will be the additional step of verifying with the Head Start center that, in fact, that child did attend. The fact of enrollment is what we want to find out about, but we may also want to try to find out something about the intensity of exposure through documenting attendance. At the end of this process, we expect to be able to reach proper conclusions about the most efficient way to incorporate this program for verifying Head Start enrollment into our main study, and have some definite options for over-sampling, if it is desirable to increase that sample size above the 2,100 who naturally would fall into the ECLS main study sample in 1998.

Question: Are you also going to collect information on whether the child attended a different kind of preschool, or a program like Parents as Teachers?

Answer: We expect data of that type from the parent questionnaires, and also we pick up any information of that type from school records. Our purpose is to collect data and make it available to researchers on CD-ROM with electronic codebooks. We spend a very small amount of time actually analyzing data ourselves.

Question: At what point are you getting parental permission to participate in this study, and how are you doing it?

Steven Ingels: We draw samples in kindergartens very early in the school term. Then we sample around 30 students per school for the field test (the sample for the main study will probably be around 24 students). As soon as those students are identified, we have to make a contact with the parent to obtain permission prior to conducting the survey. Schools will set the conditions regarding the kind of permission required. Then we will immediately follow up with the parent in order to obtain permission.

Question: How are you addressing issues of low literacy?

Steven Ingels: In doing large surveys, we have traditionally found that schools have a way of communicating with parents, and can generally tell us who has bilingual ability to convey what is in a permission form.

Answer: In response to the questions about different types of preschools or part-day versus full-day programs, please remember that we do not have any data on the children when they enter Head Start, so we have no ability in this study to control for those entry characteristics. If there are any characteristics of the Head Start program, like part-day versus full-day, that might be

Head Start Partnerships, Research, Practice, and Policy

associated with different types of families or different family backgrounds, such as family need for child care, there would be a selection bias occurring that we would not be able to control for in looking at success in school. That is one reason we are not collecting data on the characteristics of the Head Start programs. We look at the school experience of a representative sample of all children who have been through Head Start, but will not try to associate those experiences with the nature of the Head Start experience. We will, however, have a small amount of information on the child's Head Start participation through the parent interview. All parents are being asked to report about other types of preschool programs, retrospectively.

Samuel Meisels: I will try to cover our assessment batteries in the cognitive, socioemotional, and psychomotor realms for kindergarten through second grade. There are many contributors to these batteries—Don Rock from ETS, Jane Ellen Huttenlocker and Susan Levine from the University of Chicago, Sally Eckens Burnett, Julie Nicholson, and me from the University of Michigan, and the panel presenting here today. In developing our assessment batteries, we have looked very closely at all types of existing assessment batteries. While we have borrowed from existing "off the shelf" assessments, there is no single one that is being used. There are items that have either inspired us or that we have borrowed, rented, or have otherwise found their way into our assessment batteries, but virtually every item has been revised, altered, modified, and changed.

One purpose of the ECLS is to provide data to increase our understanding of the dynamics of school achievement, focusing specifically on factors that contribute to the differential achievement of various subgroups of the nation's population of children. Our approach is both descriptive and analytic. We intend to provide descriptive data on children's status at school entry, transition into school, and progression through the fifth grade by the time the study is completed. We also will collect a rich data source to enable researchers to study how a range of family, school, community, and individual variables affect early success in school. Another purpose of the ECLS is that the domains of child development that we will study will be selected because of their integral role in and relevance to, school success. School achievement, school success, what takes place in classrooms, and how we can evaluate how individual children are doing in relation to what happens in classrooms are key touchstones for us as we move forward in the development of these batteries.

The dimensions we are looking at are cognitive, socioemotional, and psychomotor. Within the cognitive measure, there are three major domains that we will be assessing: 1) literacy/reading; 2) mathematical thinking; and 3) general knowledge. Within those domains we will be obtaining both direct and indirect information from the child and the teacher. There are three socioemotional domains as well: 1) adaptive behavior; 2) approaches to learning; and 3) social competence. The first two—adaptive behavior and approaches to learning—are from indirect information from teachers and parents. Information about social competence comes directly from the child and indirectly from the teacher and parent. The psychomotor assessment is still in an early version, and no final decision has been made about whether or not we will completely follow this plan. We directly assess with the child fine and gross motor development, along with health issues.

The model that we are using for the cognitive battery is an approach to achievement gain. It provides growth measures over time with behaviorally anchored mastery levels and permits change to be studied quantitatively and qualitatively. There is no single model of development that informs precisely what we are doing. Rather, what we are interested in is the acquisition of

knowledge and skills and how the acquisition is affected by school experience—in other words, by the curriculum. We believe that a universally sequential, hierarchical model of the acquisition of knowledge is not possible for us to assess and very likely does not exist. However, we also know that various domains do lend themselves, more or less, to such hierarchical examinations. Mathematics, for example, has within it a structure that assumes that there are certain building blocks. Literacy is much less so, and science and social studies even less.

To the extent that we can, we will scale our data so that we can look at it vertically, which will give us some criterion measures about mastery at certain levels. Where we cannot use item response theory and other methods we will be trying to find out more quantitative information. For example, what does the child know at this time? In addition, we will be looking at qualitative information, such as, in what specific skills, and at what level of skill hierarchy, are we seeing this child perform? Ours is a spiral assessment in that it will be possible for children functioning at lower levels to respond to less challenging, less advanced items, and for children who may be younger, but who are functioning at a higher level, to respond to more challenging items. We believe that we will learn more about assessment through these methods, but not about performance-based assessment, because of the sample size and because of the questions that are being asked. In order to do performance-based, constructed-response measures, we would need to spend an equal amount of time training teachers to use performance measures and performance rubrics. The difficulty of doing that is immense and probably does not make sense for this kind of approach.

The first cognitive domain is literacy/reading. We recognize that language is critical to school success. It includes communication skills, (i.e., comprehension of oral and written language); comprehensive vocabulary; phonics, phonemic awareness; and reading at the word, sentence, and passage levels. The second cognitive domain is quantitative skills and mathematical thinking: numeration, calculation, and measurement. There is definitely a focus on problem-solving skills as well as procedural operations. We are trying to have our assessment reflect the NCTM standards. The third cognitive area, general knowledge, is the rubric that we use to describe social studies and science. This represents a child's breadth and depth of understanding of the social, physical, and natural world, and the ability to draw inferences. As the children get older we expect this part of the assessment to break down more clearly and cleanly into separate assessments of science and social studies, and try to have the assessment battery reflect some of the frameworks in the National Assessment of Educational Progress (NAEP), which begins at grade four. This will provide a continuum of information that is acquired from kindergarten through the entire NAEP battery. In kindergarten and in first grade, the assessment is individually administered, rather than a group-based assessment. For second grade, we are still discussing how to administer the assessments. The funding required to mount an individual assessment versus a group assessment may be the deciding factor.

The teacher questionnaire about student academic performance is going to comprise an assessment of children's experiences inside the classroom and their growth along several cognitive domains. It is important to recognize that these questionnaires can complement the data obtained by the cognitive assessments that are used in ECLS. Teachers will be asked to rate students' academic performance at each of the assessment points—twice in kindergarten, fall and spring, and then once thereafter in first and second grade. These questionnaires are administered by the teacher, one for each child, and are expected to take about twenty minutes each. Teachers are being paid to do this. Regarding the question of teacher objectivity, NCES has published a working paper that supports the use of assessments by teachers in certain cases; for example, rat-

ing students on specific performance items instead of asking them to rate children in global terms, or comparing students to a standard set of specific items instead of asking teachers to estimate grade-equivalent scores in national percentiles. There needs to be a high degree of specificity in terms of the individual items versus global domains. We have to avoid code complexity: asking teachers to switch from one type of rating scale to another in the midst of a single assessment.

We use a multimeasure, multimethod design to analyze the data that come from the domains in the teacher assessment compared to the direct assessment data. Teachers need to be knowledgeable about the constructs and their students. They are being asked to judge specifics instead of making generalizations. With this kind of background, we have constructed teacher questionnaires that will provide very useful information. One example: We ask teachers to talk about how their children demonstrate beginning writing behaviors on a continuum of how it is approached at the different age levels. In the fall of kindergarten, the teacher would be asked, using a five-point rating scale, about whether the child can use pictures, scribbles, or letter-like shapes to depict words or ideas. In the spring of kindergarten, the teacher will be asked about whether the child can use initial consonants to spell words or letter names to represent sounds, and so forth. In the spring of first grade, the teacher asks the child to compose a story with an understandable beginning, middle, and end. Then, in the spring of second grade, the teacher is asked if this child can compose stories with an understandable beginning, middle, and end and use a variety of strategies for representing meaning in the story. This example gives you an idea of one item and how that item changes. We have tried to scale all items across various assessment points.

Socioemotional development is an assessment of social competence, adaptive behaviors, and approaches to learning. Social competence, in particular, is the focus of our socioemotional assessments. We define social competence in terms of kindness, cooperation, and appropriate compliance as opposed to hostile and defiant behavior. It also includes appropriate extroversion; that is, interest expressed in people and things, and active socialization as opposed to interactions that are withdrawn and timid. Also included are pragmatic language abilities, the social aspects of communication. This assessment is indirect: asking teachers and parents to comment on the child's behavior using the *Social Skills Rating Scale* (SSRS) by Gresham and Elliott. We have made adjustments, refinements, and modifications to the SSRS. There are between 55 and 60 items on the teacher scale and a somewhat fewer number of items on the parents' scale. By third grade, children themselves can comment on these items as well.

We are also considering a direct measure of children's socioemotional growth. In the area of social competence, we are using a scale developed by Kenneth Dodge, called *The Social Problem-Solving Measure*. It is a series of 7 to 10 vignettes that are presented to the child through a series of pictured interactions between two or more children. There is a brief story that accompanies each vignette. The child is asked to respond to the stories, and the examiner makes a verbatim record of what the child says. We hope to be able to include this so that we also have a direct measure of social competence.

We are also planning to pilot a physical and psychomotor domain measure. It includes physical development, such as height and weight, and categorizations of disabling conditions. Health information will be obtained through interviews and questionnaires with parents. Finally, the psychomotor assessment looks at leg and arm coordination, eye and hand coordination, drawing a person, copying figures, block-building, and so forth.

Head Start Partnerships, Research, Practice, and Policy

Elvira Germino Hausken: I will be talking about the context of the school; that is, the types of variables that we will be asking school administrators. These variables include 1) school characteristics—private or public school, a kindergarten attached to a day care center, a private nursery school, or a private religious school; the goals and expectations of the school for the school children; the size of the school (the number of children in the school at each grade/age level); 2) physical characteristics—information about the building, the neighborhood, and the community; information about safety, crime rates, and community support; the length of the school year and whether there has been any discussion about this issue; any changes in the school area in the past three years, such as increasing enrollment or changes in faculty (teacher retirement, etc.); 3) student body characteristics—the SES demographics of the school; achievement levels; distribution of special needs students (children with learning disabilities, limited English proficiency, gifted and talented children); the mobility of the children in the school and attendance; 4) staff characteristics—the number of teachers, the kind of specialists, consultants, or special teachers (i.e., speech and language, foreign language, nurses, counselors) that are available to the staff, and if there is a librarian; the SES, educational level, and experience of the classroom teachers; 5) school organization—school funding (e.g., tuition, Chapter One, and/or special education funds); school governance; and parent involvement; 6) staff development—opportunities available for teachers and other staff, such as more course work, training in new methods and approaches; 7) school policies—kindergarten entry requirements; retention policies and who makes them; classroom assignments; 8) performance reports—types of testing used to evaluate performance in the classroom; use of standardized tests and/or work samples; type of teacher assessment of students; such as developing their own procedures or using grades; effort-based grading or comparison grading; 9) school/community resources—the availability of special programs (special education, ESL, bilingual education programs, and programs for gifted and talented children); the provision of before- and after-school care; the contact or linkage with community programs that serve children; for example, nursing or medical facilities; 10) parent involvement—activities available for parents and ways they are encouraged to participate; the rate of parent participation at the school; 11) principals' demographic characteristics—education level, experience, expectations, and attitudes about their school.

The items that will be included in the teacher questionnaires are 1) classroom environment—the physical organization of the class; student/teacher ratio; student characteristics and how this might affect teacher presentation of lessons; classroom resources; presence of paraprofessionals; aides, and/or volunteers in the classroom, what they do; organization of the classroom, what is taught, and how it is taught; 2) outreach activities—transition activities from Head Start or preschool to kindergarten; transition activities between kindergarten and first grade; amount of contact with parents and the nature of this contact; 3) teacher attitudes—expectations; beliefs about children; theories of readiness; how children should behave in the classroom; curriculum covered and focus in the classroom; how they feel about their teaching ability.

DeeAnn Wright: One of the advantages of collecting data several times is that we do not have to ask all the questions at once. The parent questionnaire is probably the most extensive of all the questionnaires. It will be a computer-assisted telephone interview, except in households with no telephone, in which case there will be a personal interview with the parent. There may be problems of language, but right now we have plans for using only English and Spanish. Although we call this a parent questionnaire, the person responding should be the person who knows most

Head Start Partnerships, Research, Practice, and Policy

about the child's education and care; that is, the primary care giver, such as a grandparent or other relative.

The information we are looking for is 1) basic demographic characteristics of everyone in the household—age, sex, race, ethnicity, and relationship to the child; 2) marital status of the parents—including if they are currently married or were ever married, the relationship between the biological parents on matters concerning the child; 3) child mobility—how many times the child moves from one home to another, and how many times the child has changed schools; 4) immigration status—country of origin, length of residence in the United States, U.S. citizenship; 5) primary language spoken at home—respondent's proficiency in English; frequency of contact with family members and other people who use languages other than English; 6) parent involvement—attendance at school activities such as PTA meetings, their child's school play; parental efforts to contact the school when they feel there is something wrong that needs to be discussed; barriers to involvement, such as meetings at inconvenient times, work schedule conflicts, lack of child care, unwelcome school atmosphere, language difficulties, or not being informed about activities going on at the school; 7) parent networks—parental contact with other parents in their child's class; 8) child care—nonparental care available for the child; 9) summer activities—family vacation; attendance at an organized program like a sports camp; 10) child's health and well-being—information about birthweight; full term or prematurity; routine health and dental care; frequency of visits to a doctor or a dentist; physical and mental functioning; 11) receipt of special services—speech therapy, physical therapy, counseling or private tutoring, participation in physical activities.

Head Start questions will be asked in the fall of the kindergarten year. We want to know if the child ever attended Head Start, and, if yes, at what age, whether full day or a part day, days/hours per week, and number of children and adults in the child's class. In addition, we include the *Social Skills Rating Scale*, which uses questions similar to those being asked of the teacher, but from the perspective of the parent. We want to know about parental values, beliefs, and expectations, what they think is most important for the child to learn in school, how they think their child is doing in school, and how far in school they expect their child to go. We ask questions about home environment activities and cognitive stimulation; educational materials in the home; TV and/or video watching; computer use; parental monitoring; neighborhood safety and resources; parent education and human capital; parent employment; family income and assets; participation in government entitlement programs; emotional supportiveness and discipline; family routines; parents' psychological well-being and health, including substance abuse, marital partnership satisfaction, and social support. Several items will have to be updated every time we interview the person, such as household roster, because that might change, but other questions will be asked periodically.

Question: I am interested in using some of the questions in the study I am designing. At what point will the questions be available?

Answer: Soon; we are expecting final OMB clearance in the next couple of months. The only things that we cannot share are the assessment batteries, because there are proprietary and copyright issues are involved.

Question: Do you have a target length for the parent questionnaire? What is the frequency of the call-back, and are there incentives for parents?

Head Start Partnerships, Research, Practice, and Policy

Answer: The length that we are hoping for is around 30 minutes per interview. Parent interviews are conducted each time we collect data from the child. Therefore, there is one in the fall and one in the spring of kindergarten, and one each in the spring of first through fifth grades. Parents are not given incentives.

Head Start Partnerships, Research, Practice, and Policy

■ Head Start Research Fair

Chair: Faith Lamb Parker, John Fantuzzo

Presenters: Muriel Hamilton-Lee, Steffen Saifer, John Fantuzzo, Grover Whitehurst, Connie Cabrera, Brooke Randell

Six recipients of University/Head Start Partnership Grants awarded from 1990-1995 shared "products" derived from their research projects. In each case, the product was developed in conjunction with a three-year research study involving the Head Start community in partnership with the University. Although the products are as diverse as the studies themselves, their overarching similarity is their creation with and for Head Start programs, staff, and parents.

Family Education and Training Curriculum: CDA Training for Low-Income Parents

Jean Rustici, Sharon L. Kagan, Muriel Hamilton-Lee

The Family Education and Training (FET) Curriculum Guide is designed to be used in programs that train low-income women for employment in child care. The guide is innovative in that it combines a comprehensive competency-based approach to training that integrates child care training, parenting education, and job readiness training. Developed in conjunction with the FET Project in New Haven, CT, the curriculum is based on an extensive review of research findings and practice from the last 30 years. It is a fresh approach that builds upon past training efforts and contours them to the needs of children and families of the 1990s.

The Curriculum Guide includes five parts: 1) Introduction—presents the background and rationale for the FET Project, with a brief description of the process used to review existing curricula; 2) Integrating the Domains—describes the rationale for and method of integrating the three domains (child care, parenting, and job readiness) into a unified, competency-based program curriculum; 3) Preparing for Implementation—outlines issues that must be addressed prior to training, such as staffing, acquiring materials, and program management policies; 4) Weekly Program Plan—is the heart of the curriculum guide, providing week-by-week directions for its implementation; and 5) Curriculum Guide in Action—is a sample of the detailed work plan for two weeks, complete with all necessary resource materials.

The FET Project, developed by the Bush Center in Child Development and Social Policy at Yale University and implemented in collaboration with the New Haven Head Start Program, is a pre-employment training opportunity for low-income parents who wish to pursue careers in the field of early care and education. Project objectives include: to prepare participants for child care employment; to prepare and assist participants in obtaining a Child Development Associate (CDA) credential; to support and increase participants' sense of confidence and success in their multifaceted parenting roles; and to enhance the social-emotional and cognitive development of participants' children.

Since implementation began in 1993, the FET Project has proven its capability to bring hard-to-reach Head Start mothers into a training/employment pathway by clearly addressing the complexity of circumstances and family responsibilities of the participants themselves, along with extensive field work in Head Start classrooms, formal training in all aspects of child development and early education, and individual attention and the provision of one-to-one advisory services. To date, 30 trainees have completed the 32-week project, with 27 (93%) having passed CDA assessment, 29 (97%) employed (either part or full time), and more positive research data in areas of self-worth, family resource usage, parenting responsiveness, and children's developmental assessments when compared to a comparable group of Head Start mothers.

Head Start Partnerships, Research, Practice, and Policy

Validity, Reliability, and Utility of a Measure of Social Competence for Head Start

Steffen Sailer

The research project, funded by a Head Start Research Fellows Grant, sought to determine the reliability, validity, and usefulness of a child assessment tool, *The Oregon Assessment*. The tool was developed to provide teachers and researchers with a measure specific to the theoretical construct of interactionism and the guidelines for developmentally appropriate practices. It assesses children across 10 developmental domains, particularly, social functioning—the primary goal for children in Head Start. Additionally, the tool was designed to reflect best practices in assessment: contextualized, dynamic, authentic, and culturally sensitive. Such an assessment tool can positively impact teaching practices, as assessment often drives curriculum.

The sample included 240 ethnically and economically diverse children from four sites in two states, including two Head Start programs. Reliability was determined by three methods, test-retest reliability, interobserver reliability, and internal reliability. Four types of validity were determined by two methods: 1) surveys were completed by 15 key professionals and experts to determine curricular, item, and content validity; and 2) congruent validity was determined by assessing 80 children with the McCarthy Scales for Children and the Vineland Adaptive Behavior Scales (Classroom Edition). The usefulness of the Oregon Assessment was determined by the use of a survey of 114 teachers and administrators.

Results indicated item, curricula, and content validity for all items, domains, and the assessment as a whole. Moderate, but significant, congruent validity was found for total scores between the assessment and the Vineland (.46 [$p < .01$]) and the McCarthy Scales (.40 [$p < .05$]). A high degree of test-retest and interrater reliability was found ($p < .01$). The usefulness survey indicated that more than 97 percent of respondents agreed or strongly agreed that the results accurately reflect the skills, behaviors, and abilities of their children and the test includes the most important behaviors to assess. Further analysis indicated that those respondents who used the assessment for two years or more felt significantly more favorable towards the assessment than those using it for less than two years.

An Emergency Literacy Curriculum for Head Start

Grover J. Whitelust, Olivia Nania, Andrea A. Zevenbergen

The Stony Brook Emergent Literacy Curriculum was developed with support from the Administration for Children and Families and the Pew Charitable Trusts. It is a year-long add-on to a regular Head Start curriculum that focuses on shared picture-book reading in the classroom and at home. The "products" of the collaborative research efforts are a training video and a curriculum book, which describe and provide materials for implementing the dialogue reading program. Controlled outcome research has demonstrated that the dialogic reading program generates sizable gains in children's emergent literacy skills. Such skills are the foundation for formal reading instructions in first grade.

The training video (Dialogic Reading: Head Start, Pre-K and K) is an introduction to the interactional techniques of dialogic reading. The video is designed to be accompanied by The Stony Brook Emergent Literacy Curriculum. Included in the curriculum is a description of the classroom dialogic reading program, a list of recommended books for dialogic reading, and a number of materials for teachers, parents, and children in both English and Spanish. The following is a brief description of the principles behind and techniques involved in the dialogic reading program.

Head Start Partnerships, Research, Practice, and Policy

Usually when adults read picture books to children, the adult reads and the child listens. Occasionally, the child may interrupt with a question or the adult may talk with the child, but it is clear that the primary rule is that the adult tells the story and the child looks and listens. Children enjoy this type of reading and can learn something from it, but they will learn more if adults read using the special dialogic techniques. Imagine if a person wanted to learn to fly an airplane, but was not allowed to touch the controls. When children share a picture book with an adult, they begin to learn how to read. They need to touch the controls. That means they need to talk about the book and read the pictures and the structure of the story to the adult.

The essence of dialogic reading is a role reversal between adult and child. In dialogic reading, the adult helps the child become the teller of the story. The adult becomes the listener, the questioner, and the audience for the child. Children learn most from books when they are actively involved.

The fundamental reading technique in Dialogic Reading is the PEER sequence. This is a short interaction between a child and the adult. The adult prompts the child to say something about the book, evaluates the child's response, expands the child's response by rephrasing and adding information to it, and repeats the prompt-evaluate sequence to make sure that the child has learned from expansion.

There are five types of prompts that are used in dialogic reading to begin PEER sequences. You can remember these prompts with the acronym CROWD: Completion prompts provide children with information about the structure of language that is critical to later reading; Recall prompts help children in understanding story plot and in describing sequences of events; Open-ended prompts help children increase their expressive fluency and attend to detail; Wh- prompts' primary function is to teach children new vocabulary; Distancing prompts help children form a bridge between books and the real world, as well as help with verbal fluency, conversational abilities, and narrative skills.

Dialogic reading is children and adults having a conversation about a book. Children will enjoy dialogic reading more than traditional reading as long as adults mix up prompts with straight reading, vary what they do from reading to reading, and follow the child's interest.

Preventing Conduct Problems in Head Start Children: Strengthening Parenting Competencies *Carolyn Webster-Stratton*

This study examined the effectiveness of using an established theory-based parenting program as a selective prevention intervention with a sample of 362 Head Start mothers and their four-year-old children. Eight Head Start centers were randomly assigned to two conditions: 1) an experimental condition in which parents, teachers, and family-service workers participated in the intervention (PARTNERS); or 2) a control condition in which parents, teachers, and family-service workers participated in the regular center-based Head Start program (CONTROL). Assessments of preintervention, postintervention, and one year later included teacher and parent reports of child behavior as well as independent observations of parent-child interactions in the home.

The results from observations at postintervention assessment indicated that mothers in the intervention group made significantly fewer critical remarks and commands, used less harsh discipline, and were more positive, nurturing, reinforcing, and competent in their parenting compared to mothers in the control group. Intervention mothers reported that their discipline was more consistent and that they used less physically and verbally negative discipline techniques and

Head Start Partnerships, Research, Practice, and Policy

more appropriate limit-setting techniques. They also perceived their Head Start family service workers as more supportive than did mothers in the control group; furthermore, teachers reported that mothers in the intervention group were more involved in their children's education. In turn, children of mothers in the intervention group were observed to exhibit significantly fewer negative behaviors and conduct problems, less noncompliance, less negative affect and more positive affect and prosocial behaviors than did children in the control group. One year later, most of the improvements noted in intervention mothers' parenting skills and in their children's affect and behavior were maintained, including their increased contacts with new teachers compared to mothers in the control group. The only variable related to a family's inability to benefit from the intervention was a history of mother's psychiatric illness.

These data support our hypothesis that strengthening parenting competence and increasing parental involvement in children's school-related activities in a high-risk sample of welfare mothers is a useful strategy for promoting social competence and reducing conduct problems, thereby reducing risk factors leading to delinquency.

Assessing Head Start Children's Interactive Play: Penn Interactive Peer Play Scale

John Fantuzzo, Kathleen Coolahan, Patricia Manz

Presenter: John Fantuzzo

Play is a primary context in which preschool children acquire the social knowledge and interactive skills with peers that are necessary for social development. Unfortunately, an increasing number of children are living in poverty, which can adversely affect the acquisition of social competencies. Head Start and other early intervention programs seek to enhance the social development of low-income preschool children. This goal must be informed by research indicating the most effective practices for low-income children. Such research depends on the availability of developmentally appropriate and culturally sensitive assessment instruments to guide the planning and implementation of early childhood intervention. However, few psychometrically sound and developmentally appropriate behavior rating scales are available for preschool children.

In response to this need, the Penn Interactive Peer Play Scale (PIPPS) was developed. The PIPPS is a teacher rating instrument for identifying interactive play behaviors of ethnically diverse Head Start children. The instrument differentiates children who successfully establish and maintain positive peer play relationships from those who are less successful with peers. The PIPPS was developed collaboratively with university researchers and Head Start teachers and parents. Identification of the most frequent and salient behaviors that reliably distinguished the "high" players from the "low" players were made during observations of children's play. These behaviors were crafted into 36 Likert-format scale items. Teachers indicated the frequency with which they had observed each behavior during play activities within the past two months. Piloting of the original scale led to minor revisions, resulting in the final 30-item measure.

An evaluation of the validity of the modified PIPPS was conducted with an ethnically diverse sample of 1,186 urban Head Start children. To assess the construct validity of the PIPPS, a series of common factor analyses were conducted. Three factors were obtained: 1) the Play Interaction factor represents children's play strengths, and includes behavior such as being helpful, comforting other children, and demonstrating creativity in play; 2) the Play Disconnection factor describes children's withdrawn behaviors, such as being ignored by other children and hovering outside the play group; and 3) the Play Disruption factor relates to aggressive, antisocial play behavior, such as starting fights and arguments. Concurrent validity was established through teacher reports of children's social competence, learning behavior, and problem behavior. The

Head Start Partnerships, Research, Practice, and Policy

measures used to assess concurrent validity include the Social Skills Rating System, Preschool Learning Behaviors Scale, and Conners' Rating Scales.

The validation of the PIPPS indicates its usefulness in identifying the interactive play behavior of urban, ethnically diverse Head Start children and for identifying candidates for intervention. The PIPPS also provides information about children's strengths and resilience in high-risk environments. These findings represent a promising response to mandates for developing culturally and developmentally appropriate assessment methods for the growing population of ethnically diverse children.

Salud Mental: Strengthening the Mental Health of Migrant Head Start Families

Connie Cabrera, Mary Lou de Leon Siantz

Full paper summary not available

A Mental Health Manual was made available in English and Spanish. It is meant to strengthen the Migrant Mental Health Component with parents, in classrooms, and with local mental health professionals. It can be solicited through the Texas Migrant Council. Training and technical assistance was available from the author.

■ Wider Windows on Head Start

Chair: Sheldon White

Presenters: Carole Clarke, Heather Weiss, Deborah Phillips

Sheldon White: This panel will discuss ideas about the future direction for Head Start research. These ideas are contained in the report "Beyond the Blueprint: Directions for Research on Head Start's Families." You can order copies of the report by calling 1-800-624-6242.

Carole Clark: I am a Head Start director and have worked with Head Start since 1982. My experience includes working in northern California with diverse populations, including migrant families. My topic is the diversity of Head Start today with a focus on migrant Head Start. The Head Start population is so much larger today, and its composition is changing. It has two special populations served on a national basis: the children of Native Americans and the children of migrant farm workers. These special populations have special geographic considerations: families living on Indian reservations or families who may cross state boundaries. Head Start in its diversity recognizes the needs of these different populations.

It is important for us to retain the oral tradition of Head Start for our families and to put it into a proper perspective. As a program director, each year I remind parents of the rich tradition of Head Start that is derived from work that took place during the civil rights movement in the mid-1960s, and how often Head Start programs started out in poor facilities, like church basements that were looked at as places of refuge. These places were threatened by having Head Start programs because, in part, Head Start was intended to promote community change as well as change in individual families. The reason I recount the origins of Head Start and its background in the civil rights movement to migrant farm worker families is that they have little direct knowledge of this social history. It is important that we look at what the commonalities are amidst our diversity and make certain that parents understand the long history of Head Start in getting us out of the church basement, both physically and psychologically. There have been many long and hard battles to maintain Head Start and to have it grow.

The portrait of Head Start families has changed. Three decades ago it would have been African American and White. The wider lens of Head Start today includes nearly one third of its families who are either of Latino, Native American, or Asian descent. A full one quarter are of Latino descent. The changing composition means that many programs have to change the ways in which they meet the needs of children and parents.

A principal issue we need to look at is language. ACYF reported that only about one third of Head Start programs have an enrollment reflecting a single dominant language group. This fact alone presents both an opportunity and a challenge to the Head Start research agenda. Perhaps the only certainty with respect to both bilingualism and multilingualism is the diversity of opinions on how best to design services and research options for these populations. There are at least as many opinions about how to go about it as there are language groups represented in Head Start. The highest number of languages represented in a single program is 32. It has been reported that 72% of all programs have enrollment of between two and three languages. While programs seek to recruit staff members who reflect the linguistic and cultural background of both the children and the parents they serve, there is daily decision-making about how and when English language instruction is introduced to children in the classroom. How do you assign children to classrooms, according to first and second language capability? How much time and effort is dedicated to the education of parents in English versus other languages? For example, I have one center where

Head Start Partnerships, Research, Practice, and Policy

there are four languages spoken. To conduct a parent meeting in four languages requires additional interpreters. If you want to run a parent meeting that does not exceed one and one-half to two hours, simultaneous interpretation and good organization have to go into your advanced planning.

Linguistic diversity does not come by itself. It is not in a vacuum. It is embedded within the broader ethnic backgrounds of the individuals within Head Start and their various countries of origin. The present cultural and linguistic diversity of Head Start families now requires that researchers adopt measures and methods of assessment that are sensitive to these differences, as well as considering issues regarding appropriate sampling and interpretation of results. This is not an easy task. For anyone who has taken a second language and has attempted to translate even fairly simple sentences, many times there are issues about choosing the correct meaning that people will understand. Anyone who has translated portions of the Head Start Performance Standards or the on-site program review instrument will understand that you have done translation twice: first, into English and second, into whatever other language that you are contending with.

With respect to the language instruction of enrolled children, Roundtable members raised a series of questions. The first that I had mentioned before was how and when English should be introduced to children. What is the impact of early identity formation for infants and toddlers who are just beginning to use language to communicate to adults? At this point in time, Early Head Start represents a small portion of the total Head Start population, but funding permitting, that percentage may increase over time. Migrant Head Start programs have served infants and toddlers for the past 28 years. What is the importance of linguistic continuity between home and Head Start for children communicating with their parents or other adult members of their extended families? I do not know how many of you have relied upon the interpretive services of say, a seven year old, to explain a fairly complicated matter, but that creates some serious issues of who runs the family by age nine.

Another question is how does first and second language acquisition affect various disabled children? In fact, how does it affect the diagnosis of children in terms of language and speech impairments? Within our program, we take a strong stance against premature identification of children learning two languages as being language-delayed. There is a body of literature that indicates that a lot of these children catch up by age seven or eight. How do you deal with other issues where there are moderate to severe types of disabling conditions and specialists, who speak only English? How do you deal with interpretation issues and sharing of resources?

How are varied parent demands for predominantly English-only instruction counterbalanced by parents who wish to promote first language retention? Sometimes there is this monolithic idea of how much parents want their children to either be able to retain or give up English. That certainly has occurred through past generations who have come to this country. What is the importance of first and second language for Head Start children if they are in an area where they may face an English-only kindergarten? Are we being kind to children in Head Start only to have them undergo shock when their first day of kindergarten is something for which they are ill-prepared? What language characteristics and proficiencies of staff promote effective language and content instruction in bilingual or in multilingual classrooms? What are the most effective strategies for first and second language acquisition for Head Start children in full-day programs or even in extended-day programs? Right now that is a small percentage of Head Start programs, but between Head Start services and other child development or day care wraparound services, that is something that needs to be examined.

The Roundtable also considered the social implications of children's language environments. If linguistic differences bear a strong influence on how children form different social

BEST COPY AVAILABLE

Head Start Partnerships, Research, Practice, and Policy

groups and how children contend with inner group conflicts, as research from Kagan seems to demonstrate, then longitudinal studies of social experience of Head Start children need to be done to see what direction program practice should take. One needs to examine the extent to which children sort themselves into social groups. The best place to look at that is out in the playground. Language that is used in the playground oftentimes is not the same language that is used in the classroom, especially in free-choice activities. That is my own speculation, not a conclusion. Having some experience with that, there are indications that that is worth examining.

One also needs to consider the influence of Head Start adult caregivers and teachers upon social group formation. Children may self-select some activities, but certainly the younger the child is, the more the adult is influencing the environment in which that child is placed. What influence will caregivers have on children who have repeated exposure to Head Start? For example, through the Early Head Start program, you have an opportunity for a child to come in as an infant, to continue as a toddler, and to be there for another preschool year or more. There is repeated exposure. If we look at the language differences of children in Head Start, we must also consider seriously the language role-modeling of adults in the classroom. To what extent are program hiring decisions influenced by the grammatical correctness and fluency of the languages other than English, and what does that look like in relationship to the nurturing characteristics of caregivers, or their knowledge of content of early childhood education? We have to choose and sometimes reserve slots for families who are Punjabi speaking or Urdu speaking. What happens if the enrollment shifts and that language is not needed anymore? If one third of all Head Start employees are current or former parents, and the majority of these parents are presumably in peer professional positions, even if they move up, there is going to be a pyramid effect. What effect does this have on first and second language acquisition in Head Start classrooms?

If we look beyond the linguistic differences of children and adults in Head Start, we must examine a number of broader cultural issues. We need better information on parents' level of schooling and the relationship to immigration status, as well as to their economic status. We need to look at differing child-rearing practices that can present major challenges to Head Start staff. These can cover anything from looking at differences in parental perception about what constitutes child abuse or neglect to what roles older siblings play in caring for younger children. These can also include the degree to which independence and competition are valued, compared to social conformity.

The immigrant status of children and their parents also is important to examine. Self-selected economic immigrant parents versus those who are forced to immigrate for reasons of violence or other disasters may have very different views about how to participate in Head Start or even participate at all. Acculturation issues for immigrants are complex, but they must be looked at, since it has been reported that half of the growth in school-age population between 1990 and the year 2010 will be attributable to the children of immigrants. The degree of acculturation is often reflected in English language acquisition and also ties to various social institutions. Head Start certainly is a social institution. If you can learn how to work with and know the different aspects of Head Start, you will know how to work with any American institution.

Head Start support staff often serve as mediators between children's homes, the Head Start center, and the public school system. The Roundtable has asked what enables family support staff to be successful in bridging home and school environments? What are the specific competencies of these family support staff in serving as mediators on the one side and cultural brokers on the other for immigrant families? What kinds of training will facilitate the effectiveness of the staff's

Head Start Partnerships, Research, Practice, and Policy

work with linguistically and culturally diverse populations? How do Head Start programs manage tension between various cultural and linguistic groups?

A special case of immigrants are the migrant farm workers with whom I work. These families have different patterns of migration in different parts of the country. Some primary issues of concern to migrant farm parents are housing, health, and sanitation. Their children may be exposed to pesticides, farm machinery accidents, drowning in irrigation ditches, and exposure to extremes in heat. These are real-life dangers to migrant parents. They have a different type of need for services than other Head Start populations, given the rural character, difficulty in maintaining and finding housing, and outrageous amounts of money that are required to pay for it. Also, in a migrant program, the whole operation is dependent upon when the peak agricultural seasons are. Head Start usually follows the school year; in a migrant Head Start program it follows the crop year. As the crops go, so does the season. If the weather is a little warmer, the families arrive a little sooner than you thought. If there are rain delays, they arrive a little later. Even problems in international trade affect what may be going on in a migrant Head Start program. These programs must have extensive hours of service. Most, like ours, have about 60 hours a week. That means that the availability of staff to parents is frequently in the evenings, and that we run all of our parent policy council meetings on Sundays, which is not a popular day to recruit community members and professionals. There is a high demand for inexpensive and high-quality fruit, vegetables, nuts, and specialty crops, but there is also a good deal of resentment about the people who pick these crops. Many times it is true that migrant farm workers are relatively invisible whether by choice or not. The Roundtable addressed issues concerning the developmental consequences of children migrating from one location to another, as well as the effects of the settling out process for children and their parents. What are migrant parents' capacity to serve as advocates for their children in schools or in other agencies after one or more seasons of Head Start experience? How are family center enrollment needs met or not met when they begin to settle out?

The Roundtable identified different things to look for in a research agenda on diversity. One is to identify current instructional practices in mixed language classrooms and to assess the effects of language mix within a group of children on their linguistic, cognitive, and social development. For example, comparisons can be made between classrooms with approximately equal proportions of children per language and classrooms in which there is a dominant language and several other languages spoken by only small numbers of children. A second focus is to enhance the understanding of how children's home and Head Start environments interact to affect their development and to assess the effects of language practices of Head Start parents who come from diverse ethnic and linguistic groups. A third is to assess the extent to which language, the migration status, and the immigration status are barriers to participation in Head Start. For example, when most of the family members are legal, but one relative is not, is there fear to sign up for Head Start? Another issue is to insure the most effective use of the family support staff with linguistically and ethnically diverse families. This could entail an evaluation of current family support and home visiting practices in a subsample of Head Start programs, both migrant and nonmigrant, that may serve large portions of non-English speaking children or immigrant children. A final issue is to capture the processes by which Head Start programs adjust to the shifting demographics of families served and identify issues for future program intervention and research. This could be accomplished by conducting a small, longitudinal, descriptive study of several Head Start programs that are changing from serving a relatively homogenous population to one in which the population is shifting to becoming more diverse over time.

Head Start Partnerships, Research, Practice, and Policy

Heather Weiss: Carole began with a notion that you need a wide-angle lens, and I am about to put you in an Imax theater. For those of you that have been to the Imax where the projection is all around you, including the ceiling, it can make you dizzy. This presentation may have a little bit of that effect on you, but once you get used to it, you will have a different perspective on things. I will try to summarize some of the Roundtable deliberations on Head Start community linkage and that set of discussions within a broader policy context that is influenced by efforts to rethink American provisions and commitments for disadvantaged children and families.

Head Start began in the 1960s as a significant component of the war on poverty. It had the kinds of goals and zeal that went along with that. With it came a whole strategy for how we were going to try and improve the lives of the poor, and that focused on not only children, but also families and communities. Thinking back to that anchor in the 1960s when many people were focused on children, there was a little lip service given to families and not much given to communities. It set a pattern that Head Start has continued to follow and that will be the direction, slightly reframed, that will take it effectively into the next century.

Twenty-five years ago, there was the classic study of Head Start and communities. It involved 58 communities that had fairly substantial Head Start programs and 7 that had none or little Head Start. The results of that study by Kirchner Associates said that by virtue of having a Head Start program in the community there was 1) increased involvement of the poor in decision-making; 2) increased employment of the poor as paraprofessionals; 3) greater responsiveness of schools to the needs of children and their communities; and 4) modification of health services to better meet the needs of disadvantaged families. These are the same goals we are trying to achieve for children in communities today as part of our early childhood policy. The context, however, is very different. We all know we are at a period where we are fundamentally rethinking our obligations to the poor. It is not the 1960s with the kind of zeal and commitment to equal educational opportunity and the war on poverty. It is a different context, which then forces us to reframe and reposition Head Start, and with that, the role of research on community and community building within Head Start. In "Beyond the Blueprint," there was an effort to examine and provide some notions about future research to understand Head Start community linkage. In the current changing policy context, what is going to be critical to Head Start's survival, and to its capacity to adapt and to be effective, is rethinking its relationship with community and also reframing the way in which it does research, so it supports Head Start within its local community as well as the Head Start national policy agenda.

There are four important transitions that we need to make. These transitions have implications both for how Head Start interacts in the community and how researchers think about research on Head Start in the community. One of the first transitions we need to make is recognizing that we need to move beyond what I call the myth of program independence. This is true not only for programs, but also for researchers. Much of our current research paradigm is based on the notion that you have a self-contained program that you can describe and evaluate. In fact, Head Start and its existing connections with community is not a bounded program. It is a permeable set of boundaries with all kinds of connections out into the community. As researchers, one of the challenges we face in understanding Head Start community linkages is to develop research strategies that will allow us to map those boundaries and to understand the consequences for child and family development of their permeability. Given the cuts in social programs, the emphasis on efficiency, and the demonstration of outcomes to warrant taxpayers' support of social services, as well as practice-based knowledge that suggests it takes a village to raise a child, we have to rec-

Head Start Partnerships, Research, Practice, and Policy

ognize that we are in an environment that should look at systems—community-based systems of early childhood services that go beyond any single program.

There are local innovations that support this. We looked at services in Newark and Paterson, NJ, Head Starts facilitated by the Prudential Foundation that located health clinics at Head Start sites. This begins to build linkages between health care providers, local clinics, and Head Start centers. We began to document the improved health consequences for children, as well as the organizational changes that were necessary to blend the medical and Head Start cultures and to get the best out of that blend. That blend has resulted in co-programming efforts to support families in which the pediatrician comes into the parenting education program and talks about parenting and health care practices together with a typical Head Start provider of parenting education services. This partnership goes beyond health care to a blend of cultures that says we have a common set of outcomes for children. If we work together and put our resources together, we will achieve outcomes that neither of us could achieve separately. That is against a backdrop of increasing devolution of responsibility from the federal to the state to the local level with accountability for outcomes. My argument here is that we have to recognize this fundamental interdependence and the importance of community linkage, document it as researchers, understand what drives it, what facilitates it, what kinds of Head Start leadership provide it, and then understand some of the consequences of it for child and family development.

A second myth that we have to get over is that Head Start will always be mostly a self-contained local to national program. There are dramatic shifts in the policy context with major implications for working with and building community collaboration. Fully, a third to a half of the states in this country now have some effort, usually sponsored by the state, to develop local systems of early childhood services. There are many states that have plans on the drawing board to devolve responsibility from the federal and the state level down to the local level. When I talk about devolving responsibility, I mean there will be local-level planning and governance groups that control a lot of the resources—federal, state, and local—that come into that community. These local groups then make decisions about how those various funding streams are going to be spent. As part of their planning process they are going to lay out a set of goals and a set of benchmarks that they expect those resources to help them achieve. With this devolution of responsibility will come accountability for achieving benchmarks for children and families in that community. Head Start is going to be a part of that and needs to start, as many already have, building bridges, participating in and providing leadership to those local planning groups that are small now but are going to be getting more power, responsibility, and authority over resources and problem-solving for children and families within communities.

The federal government has passed legislation called the National Performance Review Act. All the federal agencies are being held responsible to lay out their goals and be accountable to those goals. States are moving the same way and are devolving that same kind of a framework to local communities. As we think about the local community relationship, we have to think about it in terms of this policy shift. We must recognize that community is now going to be a major policy context within which Head Start is going to have to operate. Perhaps not Head Start dollars, but other dollars for other services on which Head Start depends will be allocated and assessed at the local community level. This provides an opportunity for Head Start to reframe and rethink their role in the local community in light of these changed circumstances. An example is Duane Crompton's work. What Duane has done is set up an operation whereby he is providing training and technical assistance to other non-Head Start child care providers in the community to help them meet Head Start standards. So if I were in a community decision-making group look-

Head Start Partnerships, Research, Practice, and Policy

ing at that, I would say they are providing quality care for the families they serve. There is also real value added for this community because Duane is now training other people who are not now nor necessarily ever going to be part of Head Start. Would I invest in him in that enlarged role as a community player adding value to my community and helping up the level of care for everybody? You bet I would. This is important because we need a common-sense approach to standards, and not Head Start stating its goals and objectives for zero to six years old. We need other parts of the constituency that serve that age group coming up with parallel standards. Duane is likely to be able to play a role in saying that our community wants a set of things for children, and Head Start will contribute to spelling out what those goals are and meeting them.

A third myth that we need to get over if we are serious about Head Start's linkage to community is what I call the "myth of clienthood" as it applies to creating communities. Head Start has a tradition of parent involvement in governance. We need to go a step further, and there are some Head Start programs that are doing that, seeing the parent as a community builder. HACAP in Iowa has a Head Start-affiliated program that is working with formerly homeless women. It makes it absolutely clear at the outset to those women that community is not something that you are given; community is something that you make. It engages them as builders of their own community, as decision-makers, as supporters of each other. It starts from this notion that you are going to build your own community and connect to the larger community. How does Head Start in fact do that? It must help build the informal connections and give parents a sense of agency as community builders—not just recipients of services, but builders of this broader community that we know it takes to raise and nurture children. We need to document that and then ask hard questions about if that kind of transformation results in better outcomes for children and a more nurturing community. We then need to determine how to research that.

There is a set of ideas in the Blueprint that follow from the kinds of linkage questions that I have just been raising. One concerns the services and community institutions that may either influence or serve these families. We have thought of Head Start as a self-contained program. We made the step a number of years ago to understanding the child in the family and program contexts. Now we are taking it a step further and saying we need to understand Head Start as a program within the community context. We need to begin to understand the ways in which that community context, for example, the availability or lack of availability of health care services, affects Head Start's capacity to meet its goals, as well as the ways in which Head Start helps the community meet its goals and objectives. It is a two-way street and it needs to be framed that way. A second set of ideas is understanding the nature and extent of Head Start's access to community resources that facilitate its capacity to offer families appropriate and high-quality services. We are beyond the point in Head Start, and beyond the point in some of our other social programs, where we think one program will meet a family's needs. This is a challenge to us, to begin to map and understand the ways in which that context affects our capacity to deliver high-quality services to children and families. Finally, there is the contribution of the presence of Head Start to the availability and quality of local resources and community institutions. Again, there is this notion of what is the value to a community of having Head Start within it?

The last myth is the role of research in understanding community and in the evolution of Head Start. We need to reframe research in several key ways so that it supports practice in the building of community capacity to improve outcomes for children. Many of you know the old paradigm, and until fairly recently we relied almost exclusively on it. That is the notion of an outsider coming in, developing the research questions, doing an experiment, and playing out the results in reports that usually are not of much utility to programs, but perhaps are of some utility

Head Start Partnerships, Research, Practice, and Policy

in national policymaking. It should occupy some percentage of our research dollars, but we should allocate more of our research attention to developing community capacity and practice-driven research. That research will help communities and help Head Start programs as they craft and examine their relationships and linkages, and the ways those linkages affect their capacity to serve children. Head Start is in the forefront of rethinking the paradigm in its recent work with children from zero to three. They have a very interesting strategy that involves much more program collaboration in setting the research agenda, and a genuine effort to develop Early Head Start's capacity to use research to inform the evolution of a new program. In the last section of the report there is discussion of the amazing amount of local innovation within Head Start programs and of our failure to understand and use the lessons from that local innovation to inform practice on a more widespread basis. The notion of local capacity building to do self-assessment, self-evaluation, and develop reasonable research criteria, and then spin that out to inform other programs and practitioners, fits with the notion of trying to build on local innovation. Research then becomes a part of the effort to evolve and strengthen programs, as well as to provide information to other providers.

One of the things that the Roundtable discussed was violence in the lives of Head Start children and staff. We need to understand the incidence and the consequences of this violence and to develop prevention strategies that come from within Head Start programs, themselves, with some kind of community-based research strategy, and then spin those out as part of a larger research and development effort. We need to better understand Head Start in its community context with the linkages, and to use research to help drive those linkages and show to the local communities the value of having Head Start as one of the players on the local scene.

Deborah Phillips: When the Roundtable was first constituted by the Administration on Children, Youth and Families, it was explicitly charged with looking at families as the unit of analysis for research. There was a recognition that Head Start is a family-focused program before that became the trendy thing to do. Much of the research had been focused on children and child development as primary issues. We were challenged by them to carve out a family-level program of research. The moment we began to delve into that as a roundtable, we realized that we were dealing with a different context. The analogy of the windows or the Imax is the analogy of that context. You start asking yourselves immediately who the families are, which gets you into issues of diversity and the nature of the communities families live in. The piece that I am going to share with you has to do with the changing economic pressures that are facing Head Start families today.

There are many aspects to this changing context that we have put under the rubric of economics. There are the changing economic circumstances and pressures that families are facing, particularly toward full-time employment and strong attachment to the labor force, but also there are changing expectations of what is appropriate for a mother to do. There are expectations that she not only rear her children, but also work and work early in the life of her babies and children. This brings changing demands for child care among the poor. Consequently, the child care and the Head Start worlds are getting blurred, whether we like it or not. Along with that, there is competition for both the mission and the dollars of Head Start. Then you inject into all of this the changing public policy debate, and particularly the debate about welfare reform. You cannot think about a research agenda on Head Start families without paying attention to these issues. The debate is largely framed in terms of moral outrage at parents. We are looking much more at the

Head Start Partnerships, Research, Practice, and Policy

grownups in this set of families than the children, and are often losing sight of the children. That is obviously not where Head Start is in the debate.

The Roundtable heard data telling us that a third of Head Start children have at least one parent who works full time. Another 15% have parents who work part time or seasonally. And another five percent have parents who are in school or in job training. They also heard, however, that employed single parents are the one group that is seriously under-represented in the Head Start enrolled population. Right there is the crux of the issue. As the needs of parents increasingly involve full-time work, and as mothers in poverty are mandated to work, serving families and involving parents has to take on new meaning. Research that is looking at that aspect of Head Start has to change dramatically. There was a survey done in 1990 by the National Head Start Association of Head Start parents. They were asked to give their highest priority for improving Head Start. They mentioned the need for extended hours and days of operation. The Advisory Committee on Head Start Quality and Expansion also talked about the pressures that face a half-day program in light of the full-time work demands that are now being placed on parents. It is not just full-time work as many of us know; it is shifting hours of work, unusual work hours. It is much more than just taking a half-day program and making it full day. It is more complicated than that. So Head Start is being challenged to articulate its relation to parents not just as parents but to parents as workers in the labor force.

The Roundtable discussed three dimensions of this set of pressures and challenges. One is the role of Head Start as an employer of parents. The second is Head Start's role as a site for job and literacy training, as a forum of parent involvement, as a way of connecting to parents. And finally, there is Head Start as a source of care, education, and nurturance for children of working parents. Paralleling that, the Roundtable identified three sets of issues that demand the scrutiny of research. The first set of research issues had to do with Head Start's role as a training ground and job site for parents of enrolled children. The second issue had to do with the implications of the new economic pressures on families for parent involvement strategies. And the third had to do with effective approaches to providing high-quality services to Head Start-eligible populations in ways that correspond to parents' need for the care of their children when they are working more than just part-day, part-time hours.

The Roundtable discussed the intersection between welfare and economic policies and Head Start policies, and the place of research at that point of intersection. At a minimum, there was a need for basic descriptive information on the sources of income of Head Start parents, and what that implies about their capacity to avail themselves and their children of the program. There was a tremendous amount of concern that the economic pressures being placed on parents are going to be felt most by programs that are serving high proportions of AFDC recipients, since those are the targets of the welfare reform debate. Those programs are the ones that need to begin to gear themselves up for what is going to happen in their communities and with their families. There was a lot of talk about the desirability of, and the possibilities for, expanding parent involvement strategies to include literacy and job training initiatives on a wider level. What are the models for this? We have the Family Service Centers that are experimenting with this now. The Comprehensive Child Development Program (CCDP) demonstration sites are experimenting with this. Can some of these local innovations be brought to a wider set of Head Start sites? What can we learn from them?

With respect to Head Start as a source of employment for low-income parents, there were a set of questions raised. They included the following: What are the career trajectories of parents who start their careers within Head Start? What are their earnings trajectories? What barriers exist

Head Start Partnerships, Research, Practice, and Policy

to translating employment in Head Start to more lucrative employment in other settings? How does parent employment in Head Start affect children's own motivation in school and aspirations for their own futures? With respect to parent involvement in this new economic context, many of the models of parent involvement that are salient within Head Start were developed in an era when the majority of parents in Head Start did not work. We need to understand better the new constraints and pressures that are placed on these families—the pragmatic issues of the amount of time parents are going to have available and when that time is going to be available.

The pressures on Head Start, and on the research agenda that accompanies Head Start are coming from a couple of directions. One is the equity issue. Is it simply the question: Do we want Head Start to be beyond the reach of precisely those parents who are struggling the most to meet the economic needs of their families and who are the target of the mandates now to go back to work? Are we going to create a situation where low-income, AFDC-dependent, single parents are going to be the group that cannot avail themselves of Head Start and create an even more two-tiered system than we have today? The second set of tensions and pressures has to do with the dramatic increases in demand for basic child care services. What is the relationship of Head Start to those pressures? I was in a meeting a week ago where the issue was raised to take that \$3 billion-plus budget of Head Start and block-grant it. We have all heard this. Isn't KinderCare or grandmother care good enough for these children? Can we still sustain the sort of special status of Head Start? That raises the time-old question of a quality research agenda within Head Start. How much is good enough for these children and how can we justify the higher quality, more comprehensive services that Head Start provides?

The Roundtable identified specifically some issues for research. How are children in poverty distributed across the various prekindergarten, Head Start, early intervention, and child care programs that exist in their communities? Can we identify inequities and access to quality programs within the poverty population itself, not to mention across socioeconomic statuses? What is the quality of care that children who are eligible for Head Start but not in Head Start getting? What is the quality of care being received during non-Head Start hours by children who are in Head Start, and is that either diluting or augmenting the effects of Head Start on those children? What are feasible strategies for providing longer hour/longer year services to children in Head Start? The Roundtable felt keenly aware of the new realities that Head Start is facing, and the issue of when and how to adapt to those new realities. Then there is the issue of when to preserve what is important from the past, and when not to adapt or cave in to the new realities. The question arises whether research can play a role in helping to deal with that continuum of adaptation and non-adaptation.

Sheldon White: The Roundtable did something that the National Research Council does not always do—we held open meetings. We had Head Start people participating in the meetings, and the room was full of Head Start people and other people interested in early childhood. We encouraged questions and discussions from people around the room. I would claim that a great deal of what we did passed orally among the members and between the members andACYF. I think that was a contribution—just simply providing that kind of thematic discussion. We are told by Head Start people that some of the ideas that we talked about have been built into existing research planning and initiatives fromACYF. A second thing we did was to issue the "Beyond the Blueprint" report. Finally, we had a series of meetings intended to build research capacity for the agency. It is astonishing that you have a \$3.5 billion program and a \$23 million research budget. It is an incredibly small research budget. That is a real problem for an agency that lives by

Head Start Partnerships, Research, Practice, and Policy

research. The agency is crippled by its capacities to find out about itself. We had a meeting devoted to the use of data archiving and the possibility of using archival data to expand our understanding of Head Start. We brought in people who were involved in creating data archives and using them. We had a meeting devoted to new forms of fundamental research. Some of you will remember that when Head Start first began, all child development was owned by Jean Piaget and all child development was cognitive development. The big issue in Head Start and everywhere else was whether we could advance the child more rapidly and close the gap in cognitive development. Developmental psychology is older and wiser now, and we have new ideas in the study of families, family systems, and social development. So we had a meeting devoted to just bringing in the interesting researchers who are looking at child development in new ways because they have ideas about what you could look at in a program, differing from the traditional measures. We had a meeting devoted to interagency collaboration. We had a meeting devoted to local initiatives and local participation. We became more and more convinced that the traditional top-down organization of research is wrong, and that it has to be supplanted or supplemented by bottom-up participation and bottom-up initiatives. We brought in Head Start center directors, and we began talking about what their interests were in research development.

We talked about what things we should leave behind. We thought we ought to leave behind some more dissemination of what we have done to parents, to Head Start directors, to educators and to other interested groups. We had many ideas about how to build up the research-practice collaboration. We left behind a strong recommendation for more research funding. It is not surprising to have a group of people focused on research saying more money is needed for research. We offered support for some kind of funded cross-agency cooperation and research organization. There is some unfunded work happening now, but it would be advantageous, not just for ACYF but for other agencies, to have a cross-agency system. Finally, what we recommended is what I am calling "Eternal Life." Here is this dissolving roundtable, but the role of the Roundtable was to integrate and reflect information about research needs, research capacities, and substantive facts about the program. It should not end with the dissolution of this roundtable. There needs to be some kind of central capacity to think about what research means. Washington has enormous capacities for funding research. It has almost no capacity to read the research or to remember what the research says. There needs to be something based either in Washington, in collaborative university centers, or in the professional disciplines that now are beginning to work more and more with Head Start. There is a need to use this research data in intelligent, thoughtful ways in order to keep building our picture of Head Start.

Audience Questions and Comments

Comment: We have been dealing for the past 10 years with diversity issues and changing life stress and measurement issues in relation to these changes in families. You said you want a family focus, but the family measures that are available and the way one goes about assessing families seems to be highly problematic. My colleague, Robert Leik, and I have worked on developing culturally specific ways of looking at family outcomes: Is that what the family really wants, given their culture and their context versus what the policymakers might think would be a "good outcome?" There are all kinds of evaluation issues and all sorts of problems with measurement. Most of the measures that we have designed are inappropriate when used with low-income, sin-

Head Start Partnerships, Research, Practice, and Policy

gle-parent families, different ethnic groups, and so forth. We do not even have good data. A lot of the measures really do not measure what they are supposed to be measuring.

Sheldon White: One of the things that many of the members of the Roundtable feel is that we have to get away from measurement as the be-all and the end-all of looking at Head Start programs. We have talked about Head Start programs for 30 years as programs that add and subtract commodities. Either they add I.Q. points or they subtract, shall we say, despair or something like that. And that is all the "measurement ethos." Many of us believe that qualitative measures, measures that are dynamic, and measures that deal with development of human beings are much richer in giving us a sense of what Head Start is accomplishing and will give guidance, not only to people at the program level, but to people at the national level. In order to look at Head Start in a more adequate way, we are going to have to go beyond traditional methodologies and traditional notions of measurement and assessment.

Question: I was curious about what a major player the public school system is. We have a public school system where the parents are basically disenfranchised. The social service center in the community school system is suddenly disappearing. All the good work we may have done seems to be slowly being destroyed.

Sheldon White: We have not spent a lot of time looking at schools and the transition from Head Start into schools until the Transition Demonstration Project. The Roundtable did not look at public schools.

Panel Member: There was pervasive awareness on the part of the Roundtable that if you are going to look at families you really have to start before they enter Head Start, follow them through Head Start, and look at them afterwards. For example, how do the skills that parents acquire because of their interactions with Head Start translate into how they interact with the public school programs?

Comment: The greatest challenge to Head Start is to help answer significant questions that every community wants answered. You could also help us know how to access our data. We all have the answers to some significant questions. If we all were answering the same questions with our data, it would help us very much, especially to see if we are doing a good job or not. The answers would be a wake-up call for us. Then we could see where we are.

Sheldon White: I think that request was completely reflected in the discussion we had at our meeting. We actually had a couple of quick engagements—I will not call them marriages, but, for example, one Head Start center director and one researcher agreed to get together so that the researcher could help the Head Start center director mine his data, to find out what was happening to his children in public school.

Comment: I believe that poverty is the issue, and also professional development. One of the real problems is high staff turnover. A two-tiered system is created where anytime people have an opportunity to leave Head Start for a more lucrative and higher status teaching job, they will.

Head Start Partnerships, Research, Practice, and Policy

Comment: It is also important to consider that decisions are not based on data alone, much as we would like them to be. Part of getting the right decision made is to develop a community of interests with the city council or county council, so that when the decision-making time comes, you already have a political base that the data can feed upon.

Heather Weiss: There are scarce resources. One of the ways to look at devolution is to say it is a way of passing the buck. As the federal government and the states have less money, they are going to move it to the local level so that we can all fight over a smaller pie. Then we are going to have to figure out the criteria on which that fight is going to take place. It is going to be largely political; we should not kid ourselves.

Oregon is an example of the way in which some of this is being framed. Some of you may know Oregon Benchmarks and their whole devolution down through their benchmarking process. What they have done is to create local groups. Those local groups now control one percent of the state's health and human service dollars that come into their local area. That means they sit around the table and allocate that money. The way they are doing it is through contracting. Therefore, if they pick teen pregnancy as the issue that they want to do something about, then they say that to the community. Local providers get the contract if they agree to meet a set of benchmarks. They are held accountable. Every six months they have to report on how many teen moms have done X and Y or whatever. Evaluation and data have not mattered until now; it is now intersecting with accountability and the contracting process. In Oregon, people are losing contracts to provide services because they have not reached certain benchmarks. So it is going to be a different game. Whether Head Start will ever be in that situation or not, I do not know. However, some of the people in communities that Head Start counts on are going to be in that situation. Therefore, this whole notion of getting your MIS system up and being able to get to the place where you are defining the benchmarks and the outcomes that your community is going to go for, is important. There is another part of this game called "we are being held accountable with no evaluation money." Somebody has to say we are probably going to need at least a few extra resources so that we can begin to answer those questions. This does not come free. You also have to educate the policymakers about what it realistically takes to get this kind of information and be accountable. Therefore, you must deal on a number of fronts.

Comment: More and more of us are recognizing the importance of research and the importance of outcome-focused measures. Some of the struggle we are facing is that we have the knowledge of how important research is, but we do not yet quite know how to do it. We have always seen research as something that someone else does. We always saw ourselves as isolated or not playing a role. We are beginning to understand that we need to play a role. I was wondering if the Roundtable discussed that at all—how to increase not only the knowledge of the importance of doing research, but how to develop the skills so that the research actually can begin to take place, or people can begin to feel competent enough to approach the proper parties so that the research can take place. I have had researchers ask me if I would like to participate in research in Head Start, and then ask what would I want to do the research on. I say, "I thought you had an idea." Therefore, I am not ready yet, and I am trying to get more ready, and I want to know how to do that.

Sheldon White: We thought hard and concretely about how to take those steps. I believe that it is going to happen. Through this process of communication with the ACYF, we have set some

Head Start Partnerships, Research, Practice, and Policy

things in motion that we expect will develop. We were a group trying to bore from within. I hope we have succeeded.

Comment: I would like to respond as someone whose program has become involved in research over the last six years. What is important is that you and your local community know and decide what it is you want to study in focus groups and develop your own advisory research committees. It does not have to be just the director who attends, either. Staff should be going out to different community meetings. Knowing what you want to study and beginning to do it is the greatest thing we ever did. It is information that has been incredibly valuable to us.

■ Evaluation of the Head Start/Public Schools Early Childhood Transition Demonstration

Chair: Mary Bruce Webb

Discussant: Michelle Plutro

Presenters: Mary Bruce Webb, Sharon Ramey, Craig Ramey,
Sue Pinzur Rasher, Margo Gottlieb, Sandy Foreman, Deborah Loesch-Griffin

Mary Bruce Webb: I am from the Research, Demonstration, and Evaluation Branch of the Administration on Children, Youth and Families (ACYF). This is the first in a series of symposia presentations from the Branch on Head Start research being conducted under the sponsorship of the Head Start Bureau. This presentation is on the Head Start/Public Schools Early Childhood Transition Demonstration program evaluation. This demonstration was authorized by Congress to provide a program of continuous and coordinated services to children as they leave Head Start and progress through the early grades of school. The demonstration was conceived as a way of determining what kinds of services might be most effective in helping children and families sustain early gains made in the Head Start program.

Under the demonstration, three-way partnerships were to be formed by a local Head Start grantee, a local school system, and a local university or other organization capable of conducting an evaluation. This partnership was charged with designing and evaluating the Transition demonstration that was implemented within that local community. At the core of these demonstrations were the key Head Start elements, including health services, developmentally appropriate classroom practices, parent involvement, and social services that were to be provided for children through third grade.

In 1991, ACYF awarded Transition demonstration grants to 32 sites that were in 31 states, and the Navaho Nation. Thirty-one of those 32 sites are still operating. The size of the sites varies considerably, with the smallest sites comprising only two to four schools, and the largest site being an entire state system. ACYF required only that these sites include the core set of elements. The sites were encouraged to develop their own individualized programs based on local strengths and needs and local resources and philosophies. As you might imagine, we have 31 completely different programs that we are evaluating. They are still evolving, even as we speak. Each of these local sites, as a condition of the grant award, entered into a subcontract with their locally chosen evaluator to develop and implement their evaluation plan. These evaluations, which include both process and outcome elements, have been ongoing since the inception of the program.

In addition to conducting local evaluations, each site is also participating in a national evaluation. ACYF awarded a contract to Civitan International Research Center at the University of Alabama at Birmingham to coordinate the national evaluation effort. Under the leadership of Civitan and its directors, Sharon and Craig Ramey, a research consortium was formed to develop the design for the national evaluation, and to decide on a uniform set of key variables and core measures to be collected at each site. The consortium is made up of staff from Civitan, all of the local evaluators, a technical work group that is comprised of experts in fields related to transition, ACYF staff, and project directors.

The design of the national study includes schools within each site matched and then randomly assigned: half receiving the Transition demonstration and half being control schools. Graduates of Head Start programs were followed from the time they entered these schools until they completed third grade. Some sites are also following a non-Head Start sample through third grade. Data collection began when the first cohort of children started kindergarten in the fall of 1992, with follow-up data collected in the spring of that year and each subsequent year. The 'sec-

Research, Demonstration, and Evaluation Branch Symposia

ond cohort started in 1993 and is being followed also. At each data collection point, information has been obtained from the children themselves, from their parents, their teachers, and their principals. Currently, about 12,000 children, their families, schools, and communities are participating in the evaluation. We are just completing the final data collection for the first cohort of children who are finishing third grade, and data collection will be finished completely next year when the second cohort finishes third grade. Because this is a longitudinal design, we do not plan to conduct data analyses for the national study until the children complete the project. However, although we do not have outcome results available, we do have some important lessons that we think we have learned from our evaluation to date. That will be the focus of our discussion here today.

This evaluation is a ground-breaking study for ACYF and Head Start. As Ed Zigler alluded to this morning, over the past three or four years Head Start has really revitalized its research agenda, and we expect that the structures and the methodologies that are being developed for this study will inform and shape a whole new generation of these multisite, community-based longitudinal studies. One of the most important things we have demonstrated to date is that partnership-based evaluations do not have to involve either/or propositions. That is, you do not have to sacrifice a rigorous, well-implemented, credible research design in order to have an evaluation that meets the needs of the various stakeholders involved. A richer, more meaningful evaluation has resulted from this partnership.

To illustrate the various kinds of methodologies and results that are coming out of these studies, there are about 20 presentations at this conference from professionals involved in Transition projects. We are going to hear first from some of our local partnerships, and then Sharon Ramey will present a national perspective on the study.

Sue Rasher: We will be talking about three of the sites. As we began working together we were talking about a partnership evaluation approach, where we faced similar challenges. The two we are talking about today are: how do you evaluate comprehensive, collaborative services; and; how do you study systemic change? We felt that if we used a partnership evaluation approach, we could get the kinds of answers that we needed.

The first question might seem obvious, but we need to revisit the question of why we both-er evaluating comprehensive collaborative programs. There has been a lot written lately about how difficult it is to do, but we want to remind you that there are some good reasons to do it. First, we believe that it improves the services. Second, it provides viable evidence for funders. Third, when you use a partnership evaluation approach, you are able to give feedback to the implementers of services. They do not have to wait for five years beyond the first delivery of services to find out how they have been doing. Therefore, it can provide information for strategic planning. Fourth, we found that it enabled us to develop systematic data-collection procedures, analytic strategies, and interpretation of data. Very often when you implement a comprehensive-services program, so much is going on that you tend to have piles and piles of information. If you design an evaluation at the same time, systems can be set in place more easily.

How do you do it? We feel very strongly that if you are going to study comprehensive collaborative services, the design must emerge from a collaborative relationship between the practitioner and the evaluator. If you want a design that includes the key elements, you need to have the people involved in implementing that program, as well as the researchers. This ensures that the perspectives of the different stakeholders and participants are taken into account. Very often when you are evaluating collaborative services you tend to be very interested in your part. If you include all stakeholders, you may be more certain that things are being addressed in context. Very

Research, Demonstration, and Evaluation Branch Symposia

often, when you get effects, you have not bothered to study the context—what has gone on in those five years to produce those effects—and you do not have a strong explanation of your results. Some of us feel that these programs should be studied because they lead to empowerment. Some of us are not so sure that that is really part of evaluation. In the spirit of collaboration, however, we laid that issue aside.

The next question concerns what well designed evaluations of comprehensive collaborative services and systemic change should include. We feel strongly that if you are going to do these kinds of evaluations, you need to include qualitative and quantitative data. Additionally, you need to have a clear conceptualization of what is to be examined. One of the fears we have is that people will go on fishing expeditions, saying, "Let's gather everything and then we will see what we have at the end." You can change your conceptualization, but you need to, at least once a year, clearly define what it is you are looking at. You also need to start blurring the distinctions between research and evaluation. We spent a lot of time arguing about what research and evaluation are. After four or five years, we are beginning to say maybe it does not matter. If you want to evaluate programs and examine outcomes instead of arguing over the meanings, design what it is that you need. If something is not pure research, or not pure evaluation, you can deal with that later.

Evaluation needs to be formative. You need to make changes in your design as you go and look very carefully at the process as well as the results. Additionally, look at the independent variable as a menu of possibilities. In this case, we are looking at transition projects; however, they change. We started with the children when they were just going into kindergarten. Certainly, transition means something very different when you are going from Head Start to kindergarten than when you are going from second to third grade.

Think of the independent variable as a moving target that you are going to look at at various times. You need to be more flexible in what you call your independent variable. Certainly it is important to have an understanding of the program's philosophy, and your evaluation must reflect that philosophy. If you have collaborative services, you need a collaborative evaluation. Otherwise, divisions between practitioners and evaluators are fostered.

The partnership evaluation model includes evaluation and program staff working together to design and implement an evaluation that gathers meaningful and useful formative and summative data. It is a true collaborative process. The model facilitates the utilization of research because you are just gathering the data, but you are already thinking in terms of utilization by including practitioners and policymakers. You have already provided the arena when you started to design your evaluation, so as you get findings, the collaboration is already set up and the mechanisms are there. It is essential that it is an iterative process so the information gathered uses multiple methodologies and your perceptions can be validated. In most cases the evaluator takes the "first crack" at synthesizing the data and presents it to the group. Then, it is a continuous process.

Deborah Loesch-Griffin: I am with the Nevada site, which is characterized by both urban and rural school districts. In our partnership, we have two Head Start agencies, two school districts, the university, and Turning Point, a for-profit consulting firm that I represent. We had many different perspectives coming together. One of the things that our local evaluation tried to document from the beginning was the key priorities of the program. Our local evaluation had a conceptualization of what an effective program would look like, but we also were aligned, even in the early stages of proposal development with the staff and the program managers to look at what they were trying to accomplish.

Research, Demonstration, and Evaluation Branch Symposia

I will share three key things that the Nevada site looked at, and then share two methodologies that are reflected in the data collection. The first was developing partnerships. In our state, there was a new effort to work collaboratively with schools and Head Start agencies where previously there had not been a partnership. The second was to establish parent involvement at schools and create a family-friendly school. The third was collaborative and integrated services at the school site by a person who provided services on site and/or referred families to nearby community services. In terms of program documentation, a clear principle that was followed was to always use a user-friendly system of assessment. We wanted as much as possible to work with Family Service Coordinators (now called Family Service Specialists). They were the core of our program at the Nevada site and were involved in case management and regular documentation of their work with families. Because of the new partnerships, they represented the agents of change in the schools, and they were the ones who were instrumental in developing local partnerships at the schools. We wanted to look at their role since they were new to the schools and new to the system. We looked at the kinds of contacts they made when they first approached the school and when they first started working with families.

In the first year of program implementation, we developed a contact sheet that was similar to a contact log you would find at any social service agency. It was very open-ended. Staff basically recorded who they met with, what the nature of the contact was, and when. In an effort to get their cooperation, which is an important aspect of working in partnership and sustaining relationships, we did not ask them to do constant recording. We chose some key times and sampled over the course of the year, doing that more intensely during the first year, starting in the fall months, and then again for a three-month segment in the spring.

In the first year, we did a thorough content analysis of all the different types of contacts in which our Family Service Coordinators engaged. They met with children, families, teachers, and community members. We learned and verified that in the first year they were in a crisis mode. It was the first time that families could access the services they needed through someone on site designated specifically for them. We found an incredible amount of direct family contact around basic needs, more like case management. In later years, we saw their role evolve. We found that for a majority of the time the Family Service Specialists were in the schools engaging parents in what we call "school involvement"—a major category. A third of their contacts involved parents, teachers, and large groups of families. They actually became a social broker in a sense, or a resource broker for families, and got them involved in schools in more new ways and roles than ever before. We shared this information in a process group with Family Service Specialists and asked them how it matched what they thought their typical roles were across the year.

I will shift now to the process group. It goes hand-in-hand with program documentation. It becomes an iterative process, and the forms evolve along with the roles and the feedback that we get from these individuals. They are critical to our having a responsive pulse on what is happening in the program from year to year. Process groups differ from focus groups in that they are ongoing. At the very beginning, when the Transition program came together, a number of things happened within the first year of program implementation. A resource management team came together comprised of key representatives from the school districts, the Head Start agencies, Family Service Specialists, and parents. We had a group that would meet on a regular basis for shared decision-making and shared resources. The Family Service Specialists, in turn, would also meet once every two weeks with their program managers. It was our commitment to use an ongoing structure rather than bringing in new structures. We tried to learn what the program was doing

Research, Demonstration, and Evaluation Branch Symposia

and what natural structures existed in which we could then be partly participant-observer, or we would ask whether we could use the meeting to facilitate a process that we needed to learn about.

We asked the Family Service Specialists to brainstorm about the characteristics or qualities of families making successful transitions. We then asked them to generate a list of those qualities of families who they felt made less successful or poor transitions throughout the years. We took that information and transformed it into a survey so that we could systematically gather more information about each of their families. We have used this process with families, transition teams, and teachers. It is an effective strategy for us. Not only does it allow us to keep in touch and adjust our design as we need to, but it also gives direct feedback that produces richer, more valid information.

Sandy Foreman: The Arizona project is located in Phoenix. It is in the inner city and consists of three school districts: Baltz, Creighton, and Osborne. In the greater Phoenix area, we have over 58 school districts. The Transition consortium is a Head Start grantee—Southwest Human Development Head Start—of which I am an employee. In addition, a major partner is the Morrison Institute at Arizona State University in Tempe, particularly Andrea Green.

I represent the practitioner's point of view. I have used research to improve program quality. As I became part of this project and developed a relationship with the primary researcher, I gained a greater respect for what it takes to be a researcher and how research can work with program. I entered into the experience with an open mind regarding research evaluation, and without a lot of negative experiences that perhaps some other Head Start people have had.

One of the requirements for a successful partnership evaluation is that the partners learn to trust one another. It is crucial that they develop a relationship of respect and understanding for each other's fields and open-mindedness about hearing whatever the other person may have to offer. I have seen Andrea over the years as someone to whom I can go to toss around ideas. She has had as great an understanding and knowledge about the project as I have because we have been able to share continually over the years. Besides developing a level of trust in that relationship, there is also a need to maintain a certain objectivity toward one another. I know that Andrea was able to walk that fine line between being understanding, being sympathetic to the program objectives, and also being objective about where it might need to improve and what the weaknesses in addition to the strengths might be. It is easy to get too close to your subject and wanting it to succeed, and therefore not wanting to see some areas that need to be improved or to see ways of doing that.

Two methods that we found effective in Arizona are participant-observer and focus groups. First of all, participant-observer sounds to me like a contradiction. A person is a participant in events and discussions or they are an observer of those discussions and events. This particular methodology requires someone who can walk both roads simultaneously. It means that the evaluator sits in on all the key program meetings during which decisions are made, services are discussed, and problem-solving takes place. In Arizona, those key meetings have been called "Transition team meetings." These meetings involve elementary school teachers and the Transition family service staff; in our case we call them family advocates. Included are Head Start personnel who may be located at that school site or who provide services to Head Start programs on or near that campus, principals, and other administrative personnel at the school. Occasionally, other members of the team, such as school nurses and social workers, attend for particular purposes. The Transition team meetings are a primary way at each site that we have of communicating, solving problems, and dealing with issues.

Research, Demonstration, and Evaluation Branch Symposia

The evaluator's role is not only to make observations, document discussions and the process of decision-making, but also to make announcements, update people on the evaluation, and help people who are involved in the program have the information they need about the ongoing evaluation.

The second methodology that we have used at our site is focus groups. These have been done yearly and separately with each of the major stakeholders: parents, family service staff, teachers, Head Start managers, and principals. The observer and recorder take note of the major focus area and of the comments that are made. In addition, these sessions are audiotaped. The evaluator has shared the transcripts of those audiotapes with me, and this has been very helpful. Some of the information is confidential, but I can use it in planning the next year's training with staff.

Margo Gottlieb: I am from the Illinois site. This multifaceted Transition program is infused with many different kinds of partnerships. Evaluation partnership seems to be the umbrella for the many kinds of relationships we have developed among many different constituency groups over the last five years. Probably the first partnership is between Sue and me because we represent two independent agencies. We partnered because we realized that with the comprehensive nature of this program, two heads were better than one. Our partnership has facilitated the partnership with the school district and with the Head Start agency. To further illustrate this partnership, I am both a practitioner and a researcher. When I work with Sue, I am a co-principal investigator. However, as an experienced practitioner I have worked with Linda for 15 years in other projects. A partnership evaluation brings many different roles into play and enables the people to see different kinds of relationships that are enabling for the program itself.

In Illinois we have 17 schools, 8 target schools, and 9 comparison schools across three independent school districts. In Carpentersville, IL, our grantee is School District 300, where Linda resides and is the Assistant Superintendent. Our first set of partnerships was fusing the philosophy of the school districts and gaining an understanding of what the mutual goals of this project were. I want to give you some examples of partnerships that occurred during different phases of the project in Illinois.

With the first one, we had this common ground. We had the program anchored in a common set of goals. We wanted to look at an evaluation planned in a collaborative spirit. Ultimately, what we wanted to do is to document program implementation across five different levels. Although we were mandated to look at the child, the family, the school, and the community as a group of partners, we wanted to see what was happening programmatically, as well, and across four different domains: social services, health and nutrition, family involvement, and education.

Unless you are grounded in a common philosophical base, the disparity is never compensated for. Basically, we wanted to investigate the evolving conceptualization of the construct "transition," and look at strategies and effects. Our second goal was to do this in a systematic way through program documentation. In order to do this, we had to operationalize the plan through the cooperation of many different people and many different constituency groups and provide ongoing feedback. Before the evaluation got underway, every phase of evaluation was considered a partnership starting during the planning year. The conceptualization was born from a partnership.

We strongly believe that in this partnership, information is provided on an ongoing continuous basis that moves from evaluators to program people and back to evaluation. It is constantly being refined, improved, and modified to better meet the needs of the program. Not only is the

Research, Demonstration, and Evaluation Branch Symposia

systematic collection of data done on a formative basis, but also on an annual basis we tried to do a little meta-analysis of some of the local questions so we could be able to make some general statements and synthesize what happened over the year. If we wanted to capture some trend data, we had to have each data point first.

We always reported findings with input from the Project Director. She saw the first draft of the report and gave us suggestions. We sent it out to other members of the team and they gave us their feedback. Again, it is a partnership: planning, implementation, data collection, analysis, and reporting the findings. By the time we were ready to reach out to all the other stakeholders, we had a firm grasp of the data. Overall, those are some of the elements that we incorporate into Illinois' partnership evaluation.

Now I am going to focus on two methodologies that are being utilized at our site. The first is classroom observation. This methodology is used at all 31 sites, but each site wants to capture those idiosyncratic features that best portray their site. We brought all our measures to the evaluation advisory board and asked them how we could make them meaningful for Illinois.

For the classroom observation, we added two additional measures. We also felt it was important to obtain descriptive data of what was happening in the classroom. We had a firm sense of developmentally appropriate practices in the pre-K programs, but not what was groundbreaking in kindergarten, first, second, or third grade. What do developmentally appropriate practices look like? We struggled with this as a group: evaluators, administrators, and facilitators. As part of classroom observation, we had a focus group with the teachers in individual schools. When we went into their classrooms, we tried to observe what was happening. What were the interaction patterns between teachers and children, what were the physical elements of that classroom, what were some of the domains of developmentally appropriate practices, and how can you describe them as the children move through this transition process through third grade? We also are using an optional measure, called ADAPT, from the national core, that captures developmentally appropriate practices. We found in the initial analysis that by using all four measures and multiple means of data collection, we were able to have a more comprehensive understanding of the construct.

Another methodology that we employed was the use of narratives. Right from the inception of the program, family service workers told us that we were not capturing what happens every day—the successes they experienced. They wanted to be able to express themselves, to reflect on what they had done, what had been the most and least satisfying aspects of their job that month. We developed two narrative instruments that enabled family service workers and teachers to reflect on the process of their accomplishments, on how they may have done things differently.

One of our main questions is, "What is the evolving conceptualization of this project?" We found that it changed over time and that originally the family service workers were focused on their piece of the project, such as how they were going to work with the families assigned to them. We were able to document systemic change in their attitudes over time.

Our evaluation advisory board members are working partners and we meet on a bimonthly basis. They are privy to everything that happens in this project and they have been part of the process since the initial days. We have shared with them the national core measures and they have helped us make some very difficult decisions. We rely on their input. They helped us hone in on specific problems, refine instruments, and design and develop instruments. Right now they are helping us prioritize the data analyses and develop a dissemination plan. The information that we are about to give to family members, school boards, teachers, and administrators is meaningful and understandable, thanks to the advisory group.

Research, Demonstration, and Evaluation Branch Symposia

Sue Rasher: To sum up, we feel strongly that the partnership between the evaluators and the program stakeholders enhanced and strengthened the ability of the evaluation to understand the program's context, as well as its effectiveness. We feel that it gave us a unique opportunity for understanding and improving the program and providing informal feedback. It broadened the scope of traditional evaluation, and evaluation questions and methodologies emerge while the program is going on. It helped reveal new directions and identified unanticipated program impacts. It was a tremendous challenge to evaluators to maintain a systematic, objective orientation and analysis. It offered the evaluators an opportunity to maintain a close and meaningful relationship with program staff.

Sharon Ramoey: I am going to tell you how the conceptual model has evolved, where we are in terms of measurement, and how we are going to present the findings of this very ambitious, well funded, and generally well conducted intervention that lasted for four years and extended comprehensive, continuous Head Start-like services to more than 8,000 former Head Start children and families and more than 4,000 non-Head Start children and families who are participating in the study. I might add that the number of those actually receiving services is much greater than the 12,000 participants in the national study.

Before presenting any outcome results, we will present in detail what happened. We will do that as the basis for informing the model—the analytic strategy for the national study. We have a series of five questions and have data being collected on all of them.

The first is: "How has the program actually been implemented at the 31 sites?" In the interim reports to Congress, we have evidence that all sites have activities, although there is tremendous variation in when they got started. Not all of them were up and running in the first year of implementation even though they had a full year of planning. The second question is: "To what extent have comprehensive and continuous Head Start services actually been provided?" The third question is: "What are barriers and difficulties are associated with implementation?" This is important because, in the event that elements of this project appear strongly associated with good outcomes, other programs could benefit from the lessons learned from these 31 sites.

Midway into the study,ACYF, in the spirit of looking at positives as well as negatives, asked us also to identify facilitators. Fortunately, there is a lot of qualitative data, and retrospectively we can identify some of them. We are now identifying them prospectively for the final phase of the study.

The fourth question is: "What are the characteristics of local sites that lead to more successful or less successful program implementation?" Again, remember, program implementation does not tell us whether anyone benefits. It is important to think about this because some sites serve more than 800 families with the same dollars that other sites serve about 120 or 150 children and families. Some worked with only one or two school districts; others worked with 10 or 20 with the same dollars. Again, one can see different visions of how to spend the money and change and enhance the lives of former Head Start children and families.

There are rural and urban distinctions, and places that had a lot of experience while others had none. The notion of supporting children in a comprehensive way in the first four years of school is far from new. What is new is the vigor and investment in a program that is being done systematically and accompanied by a study. A number of these sites already had transition-like supports in place. Did that affect how they implemented the program? We are looking at those kinds of variations.

Research, Demonstration, and Evaluation Branch Symposia

Finally, as a result of this program, what kind of institutional or systemic changes will be evident at the sites at the end of the project? Will school districts have changed some of their regulations or their policies? Will we have family centers and learning resource centers in many elementary schools at the end with funding that will continue? From the beginning, this program required local sites to plan for long-term institutionalization of the successful elements. Has that really been taken seriously? We are measuring that. We will provide answers to all of these questions before we present the data about how the schools, families, and children are doing.

There were several program components that were required: 1) a governing board that had authority over the money and the hiring and firing of staff; 2) very vigorous parent involvement activities; 3) comprehensive social services and health and nutrition services at the two-generation level (family and child); 4) developmentally appropriate practices in every classroom where a former Head Start child entered during the course of the study; 5) family needs assessment and individualized transition plans on a year-by-year basis; 6) inclusion of all the children with disabilities, which would be presumably at least 10% of the participants, and as much as 17% based on other national surveys; and 7) cultural diversity as a theme in the enactment of all of the above services.

We measured these components during site visits that we conducted over a three-year period by colleagues from the different sites, outsiders from the National Research Advisory Panel, and people from the national study office. It was a team process of gathering systematic program documentation from each site, doing content analysis, and coding it.

In addition, at this point the local sites themselves are doing self-criticism and self-ratings on how they have enacted each of these elements. They are doing it in a time-distributed way, because some of the sites that were slow to start have successful and vigorous programs while some that started off with a bang sometimes fizzled, and some developed at a steady rate or began strong and remained strong. We need to take that into account because we have cohorts of families entering at different times, and they may get different treatments even though they are within the same site. We also have variables such as the strength of the local partnership and the coordination that occurred in order to get comprehensive services to families that we can measure and estimate in some way on an annual basis.

I would like to remind everyone that this program, unlike any other poverty program, was not focused only on former Head Start or poverty families. The idea was that when former Head Start children enter a classroom, much of the treatment would be available for all children and families. For example, rather than have a group of low-income children get free dental care, it was to be a classroom-level intervention. If there were other families in the classroom that needed services and supports, they would get them too.

Again, how this was interpreted varies from site to site. However, as described in the Congressional legislation, it was to be offered. One could imagine it theoretically benefiting other children. We have a non-Head Start longitudinal sample being studied for kindergarten, first, second, and third grade.

Next, we focus on the biggest obstacles to doing this evaluation well and how we have tried to reduce or solve them. The first is high attrition and mobility that always occurs in low-income families, and that could even be increased if you have the vigorous involvement of Family Service Coordinators trying to get families out of bad neighborhoods. If it is a school-based, classroom-based intervention and the children are moving around, it is difficult to get a continuous treatment. That is something that plagues the study. We estimate that at the end of third grade only about 50% of the children will remain in their originally assigned treatment con-

Research, Demonstration, and Evaluation Branch Symposia

dition. What do you do about that? Do you ignore those children? Do you say the program is a failure since it only treated half the people it hoped to treat? We decided to consider the amount of treatment, the duration of treatment, and the exposure to the treatment as a variable for all children in our analysis. That is very important. It is not treated/untreated; it is how many years of treatment did each child and family receive.

Another obstacle is program documentation. Sites differ at the school district level, the school level, and even at the classroom level within schools, based on how willing teachers were to get extra training, to change what they do in the classroom, and to allow the program to become active in the children's educational experiences. Every site has tremendous variation within site as well as across sites. What do we do with literally hundreds of variables that provide descriptions in a qualitative and quantitative way? How do we group them in some way to then make sense of it? We have struggled for years with it, and what we are now doing is placing programs in different categories that have anchors of how they have implemented the program. We put them in ranges of different kinds of program implementation. Even at low levels of implementation, enacting new services and supports could make a difference. However, based on a child development model, the difference they would make would vary. We can now link the intensity of program implementation in each of the components to expected outcomes. What we are avoiding, however, is trying to come up with a single score to capture each site, because it washes out meaningful differences. If you have two schools that enact a fabulous program and cooperate fully, and two schools that do not, to just say that was a medium site washes out important data. Finding out whether a program could succeed if it were enacted well could make a difference. We need to understand that.

We have tried to preserve a hierarchy of embeddedness, where the child is embedded within the family, and the children and families are embedded within classrooms, schools, school districts, a treatment condition, and then within sites. The unique analytic issues concern the embedded nature of child development itself. Children are not only getting a classroom treatment; the families are getting services. The families are not only getting a program to enhance the family learning environment; their schools are being influenced. Historically that is what we have done, in part because it is so challenging to add many variables to a single data analysis. This is difficult to do when there are relatively small N sizes. The strength of a national study is that there are 12,000 cases with a lot of variation; therefore, modeling of individual differences may be done that may make sense of what previously would be a hopelessly complex situation.

One should take into account where each child begins and not think all growth is linear. Not everyone gets better at a steady rate; there can be fluctuations and variations that are worth studying in relation to the children's social ecology and supports. We now have techniques that allow us to adapt quantitative research techniques to what we are doing and, in fact, we are doing individual growth trajectories on both children and parents so that year by year we can take into account where they began, some life circumstances that affected them, and situations that will very likely alter their growth, and look at meaningful patterns of change over four years for different groups of people. We are using individual growth curve analysis as the primary mode of looking at outcomes.

We have a concern about the motivation of comparison subjects to stay in the project. We have had local sites that have been vigorous, and the dropout rate in the comparison group is not any greater than in the treatment group. That has not plagued us the way people thought it would; however, we do offer incentives. All families are paid for their participation, and there are other incentives to schools and teachers for their participation.

Research, Demonstration, and Evaluation Branch Symposia

Finally, we have a situation where over half the sites, in both control and comparison schools, look like they are doing some of the exact same things. This speaks to two things. The first is that if a neighboring school or school district is doing something that looks beneficial to children or families, another school wants to copy it. In real life this is what we would like. We would like this spread of effect. In addition, we have done an analysis of who got funded. The places that got funded are, compared to the nation as a whole, among some of the richest and most resourceful communities. That means that they were able to put together a competitive application in less than two months in the summer when most school districts are not operating. Although they used a random design, one could imagine that the same people who put together the team to do the competitive grant might also put together other teams to bring in money to the schools or the school district that did not get funded. That is in fact what happened. Some of the comparison schools received funding equal to or greater than the treatment schools. We cannot as the national evaluators ignore this fact. We cannot only look at differences between the treatment and comparison families, and forget that some comparison families got more than the treatment families at some sites. This has plagued us year after year. What we are doing is quantifying the level of services and supports, both at the individual and site levels. We have a profile for the comparison schools and families that looks like the treatment profile. At the end of the study, one would like to be able to say that if children and families get these services and supports, that enhances their developmental outcomes, and both generations are enhanced, and not just report how big the difference was between the two groups at each site. We have built that into the analytic model.

Finally, there was—in terms of attrition and mobility—huge crossover. We have close to one third of our sample in the treatment group in the four years moving to comparison schools, and many of the children in the comparison schools moving to treatment schools. In some sites, we actually have comparison or control children with two years of treatment. At both the conceptual and statistical levels, we have attempted to address these types of problems.

We are now moving to the outcomes and how they derive from understanding variations in program implementation and the “dosage” received by each child. We have three major outcome areas: family, child, and transition. For family outcomes: 1) the degree to which families participating in the program shows the expected outcomes (we have focused on very few outcomes, but each has many measures); 2) the degree to which parents are more involved in their children's school and learning; 3) the rate of parental involvement over the four years; 4) the rate of improved family and parental functioning in the areas of self-sufficiency, personal well-being, mental health and general health-related activities, and engagement in the workforce. These questions represent a family focus as a result of participating, taking into account the amount of intervention they received and the degree to which the treated and untreated subjects differ at each local site. We then will move to a composite, doing a meta-analysis of the data from the individual sites.

The next set of questions deals with the child outcomes. We looked at something “touchy-feely.” Each year, we asked children whether or not they liked school and how much, how well they got along with their teachers, whether their teacher taught them new things, whether their parents cared about how well they did in school, and how hard they tried to do well in school. We got good differentiation, even from children as young as kindergarten age. We took their attitudes toward school into account. We expect to find that children doing well throughout 12 years of school and in life start off with positive attitudes that are maintained. We know that in kindergarten and first grade almost all children love school. We also know that by third grade, many

Research, Demonstration, and Evaluation Branch Symposia

children do not. Therefore, we are looking at the developmental trajectory of positive attitudes. In addition, we are looking at their steady rate of improvement in social-emotional adjustment and their progress in reading, math, and receptive language. Then we are looking at higher rates of attention, and lower rates of special education placement over the first four years in school.

The last area, transition, looks at who has poor transition experiences and why. Did it have to do with something about the program? Did it have something to do with their ecologies? We have set up the data analysis so that we have some strong hypotheses. However, we know we will not be comprehensive, so the data set is available for analysis to all our colleagues in the consortium. Other researchers may have access to it through those in the consortium. Eventually, it will become a public use tape.

Audience Questions and Comments

Question: Early in the project, there was some attempt to address issues of ethnicity and culture. Are you still pursuing this line of data analysis?

Sharon Ramey: Yes. We established work groups that have proposed exciting data analyses for ethnicity and culture. We know we need to address these issues, but we are not certain how. From our National Advisory Group, Sandra Daugherty, an economist, and Diana Slaughter-Defoe, a psychologist, are interested in interventions with African-American children. They have been working hand-in-hand with a group headed by Evelyn Lucky from Ohio in planning particular analyses around different ethnic groups and constructs such as parental values. We have in the national data set how much parents value different behaviors in their children, the degree to which that relates to their child's progress, the degree to which parent values are consistent with or at odds with teacher values about children's behaviors, and how that affects parent involvement in schools.

Question: Why didn't you use the parent policy council to represent the parents in the project?

Answer: The project is in the public schools, but some projects started out using their policy council as their governing board. Because the representation that was needed were parents of the children in the schools, eventually separate governing boards (that might have policy council members) were set up, but they are modeled after the policy councils.

Question: Were teacher characteristics considered when randomizing?

Sharon Ramey: Teacher characteristics were not considered when the randomization occurred. If randomization was done by child, then as they moved from kindergarten to first and second grade, comparison and demonstration children ended up in the same classroom. That could not happen because treatment group teachers had training on how to implement developmentally appropriate practices. That was a practical reason why we could not randomize teachers.

■ Evaluation of the Head Start Comprehensive Child Development Program (CCDP)

Chairs: Michael Lopez, Helen Raikes, Louisa Tarullo

Presenters: Yonette Thomas, Robert St. Pierre, Joan McLaughlin, Judith Jerald

Michael Lopez, *Branch Chief at the Research Demonstration and Evaluation Branch in ACYF and Federal Project Officer for the Comprehensive Child Development Program (CCDP)*: The focus of today's presentation is partnerships among researchers, practitioners, and policymakers. There are some examples of partnerships that we will illustrate, as well as providing an overview of the study. But first, some background on CCDP.

One of the basic cornerstones of CCDP is the concept that the earliest years of a child's life are critical to overall development. The more sobering news is that there is adequate research evidence that children growing up in low-income, single-parent families and/or communities that are confronted with multiple sources of stress are especially at risk for a variety of difficulties later in life. There is a large body of evidence in the literature that documents the positive effects of preschool intervention programs for low-income children. However, the data is not as comprehensive, or as complete, for early intervention programs for infants.

With that as a backdrop, in 1988 Congress enacted the Comprehensive Child Development Act, which provided for the establishment of the Comprehensive Child Development Programs. The purpose of this initiative was to provide intensive, comprehensive, integrated, and continuous support services to children from low-income families from birth until entrance into elementary school—a rather ambitious agenda. The goal of providing these services to children over time was to enhance their intellectual, social, emotional, and physical development, and to provide the necessary support services to parents and other household family members to enhance their social and economic self-sufficiency.

As a result of this legislation, 22 CCDP programs were funded in fiscal year 1989, and two additional programs were subsequently funded in fiscal year 1990, for a total of 24 programs under what we call Cohort I. In fiscal year 1992, Congress increased the appropriation for CCDP and directed that additional grantees be funded along with directives to add quality enhancement money. Thus, a second set of 10 CCDP programs were funded with these additional resources: 8 in fiscal year 1992 and 2 in fiscal year 1993—Cohort II.

The Cohort I programs are close to the end of five years of service delivery—in some cases, closer to six years. In addition, ACYF funded a management support contractor, CSR Incorporated, to provide administrative and technical support to the Head Start Bureau in the conduct of the CCDP efforts and technical assistance to the grantees. CSR is also conducting a process study of the implementation of the CCDP programs over their life spans. The act also required that an evaluation be conducted and a report be submitted to Congress on the effects of the Comprehensive Child Development Program and on the development of the children and their families served by the program. The CCDP impact evaluation is being conducted by Abt Associates. Because CCDP provides continuous services over this multiyear period, and because the effects are expected to occur over time, the evaluation is longitudinal in nature and calls for assessing children and families at multiple points in time across several years. Similarly, given that CCDP programs provide comprehensive services, the evaluation design includes a broad measurement battery that will allow an assessment of anticipated outcomes across a diverse range of child, parent, and family functioning. This evaluation was initially funded in 1990, and we are

Research, Demonstration, and Evaluation Branch Symposia

currently in the process of analyzing the recently completed five years of data that have been collected. It has an anticipated completion date some time this fall.

There are several ways that the researcher-practitioner partnerships have been illustrated. Judy Jerald, from the Brattleboro, VT, Cohort I CCDP program, will talk to us about how she as a program person and project director has taken research information and used it at the local level to help track families, improve her program, rearrange services, and, most importantly, leverage funding. She exemplifies one of the more creative approaches of piecing together a variety of sources of funding to create a full range of service delivery programs for families, not just CCDP families. Yonette Thomas from CSR is going to talk about Cohort I, describe the grantees, and present an overview of the process study that CSR is conducting. Bob St. Pierre from Abt Associates will talk about the Cohort I impact evaluation and describe the study design, as well as the various analytic approaches that will enable us to analyze the data in a manner that we can take into consideration variations in site effects and variations in levels of participation of families. Even though they are provided access to the program for five years, we know that families are mobile: they move, graduate out of the program because it was successful, or drop out of the program. We also look at various subgroups of interest that might come out of the sample; for example, a sample of teen mothers was included.

We will then talk about the Cohort II grantees, where they are, and how they are similar or different in design, both in terms of the program and evaluation design. Joan McLaughlin will talk about the demographic profile of families and some interesting presentations on who these families are and some of their service utilization patterns. Finally, we will provide a glimpse of the longitudinal follow-up study that we recently initiated. In eight of the Cohort I sites, a decision was made to continue to follow these children and families for an additional five-year period, based on the assumption that even though these children and families were provided services for this five-year period, some of the effects may be more longitudinal in nature and may take longer to track over time. We also wanted to see how the effects are sustained as the children move into elementary school.

Yonette Thomas: I will give an overview of the process study and a description of the grantees themselves. The process study was designed to address policy questions about implementation and cost. The study includes the following five main research questions, and looks only at families who participated in CCDP:

1. What are the characteristics of the CCDP families who are served by the 24 programs, and how have those characteristics varied as the programs progressed across the five years?
2. What are the characteristics and quality of the CCDP projects, and how have those characteristics changed as the projects developed across the five-year period?
3. Which factors account for differing levels of service utilization, family assessment, and family satisfaction among the CCDP families? Which families utilized more services, which kinds of services did they utilize versus other families, and what were the reasons for that?

Research, Demonstration, and Evaluation Branch Symposia

4. What impact does CCDP have on the community? The CCDPs are situated in communities that range in resource richness. How has the CCDP affected that community's services integration pattern, service delivery system, and vice-versa? How has the service delivery system in the community affected the CCDP?

5. What are the costs of the CCDP program—costs of providing services to these families and costs of implementing the CCDP program?

The first question about the characteristics of the CCDP families focuses on describing the demographic characteristics of all the program families served by CCDP: ethnicity, sociodemographic factors, and the types of goals these families were working toward while they were enrolled.

The next question about the quality of the CCDP programs focuses on describing the characteristics and quality of the CCDP projects themselves. What kinds of programs were they? Were they programs that were situated in a university-based setting or in a community-based setting? What were the organizational frameworks of those programs? We are seeing that organizational framework is a very important factor in how programs process along the way. For example, the position of the CCDP in the umbrella agency is important. The level of importance that CCDP has in the grantee agency shapes how that CCDP is able to bargain and barter for services. We also look at the role of the management, how management affects the service delivery patterns of the program, and how it affects the implementation and the types of services provided by the projects. This question was also used to assess the quality of key services in a subset of 10 of the projects. We looked at quality of case management, early childhood education, and administration in these 10 projects, and did a separate data collection effort.

Which factors account for differing levels of service utilization, family assessment, and family satisfaction among CCDP families? This question includes a series of questions about the relationship between program implementation, quality, and goal attainment (goals the families identified that they wanted to achieve while they were in the program and how the program enabled them or helped them achieve those goals) by the CCDP families.

What impact does CCDP have on the community? This question focuses on the relationship between the CCDP project and the community it serves. It addresses policy questions about service integration and how community context affects, and is affected by, program implementation. The CSR's MIS and ethnographic data are also being used to estimate the resource richness of the CCDP communities. In some instances it impacts on the services available in general, but, more specifically, the services that the CCDP accessed and brokered for the use of the families.

The final question focuses on the costs of CCDP. This research question focuses on estimating the overall costs of just 10 of the CCDP projects. We did an in-depth study looking at quality, and our attempt was to relate the cost of the program to the quality of the program and family goal attainment. These data, together with other process data on program families, such as utilization patterns, will be used to help explain variations in the costs of implementing the CCDP projects.

CSR is using individual family and program-level MIS data collected on varying schedules by program staff and ethnographer reports that were completed three times a year. There is a standard MIS system that is implemented at each site. This system was used both as a management monitoring tool and also helped collect process data for the process study. In addition to that, each project had an ethnographer. Anthropologists are always cautioning us that they are not ethnographers in the purest sense of the word, since ethnographers stay and live with a group of

Research, Demonstration, and Evaluation Branch Symposia

people for at least three months and use participant-observation studies. Most of our "ethnographers" are anthropologists. They are residents in the community and are usually associated with the local university. They spend a significant amount of time on site interviewing program staff, families, and community members, and looking at the kinds of services the families are accessing. They look at the issues affecting families, the role that CCDP is playing in the community, and so forth. That data has been collected and is currently being analyzed to give us an objective view from an outside person.

The cost information was collected for one fiscal year, 1994. Based on our data, we saw that as the year when a majority of the projects were in a stable phase. They had passed their initial recruitment of families and were working with multi-issue families, learning to provide for the needs of the families and working in the community developing systems that would enable them to implement a fully working program.

Two separate research groups, conducting the two studies, were working together on identifying a study sample: which people would be in the process sample and which in the impact sample? The MIS data was very significant in providing that sample. The Abt study includes data on comparison families, whereas the CSR study includes data only from program families, except for some background information on comparison families. The Abt study includes 21 sites while the CSR process study includes all of the 24 sites. The two research groups have agreed on a common definition of who is considered participating or nonparticipating. Participating families are those who have at least one assessment in the MIS.

Robert St. Pierre: In the CCDP study we are trying to assess the effects of the program on participants. We focus on primary research questions that relate to the effects on children's development. What are the effects of CCDP on the cognitive, social, emotional, and behavioral development of children, and on children's health status? What are CCDP's effects on birth outcomes for children who are born while their mothers are in CCDP? Generally, that means children born subsequent to those who are referred to as the focus child who qualified a family for entry into the program. Once families came into the program, additional children were born. Those children have a particular reason to be interesting because programs have had a chance to work with mothers on reproductive behaviors, seeing that they receive prenatal care.

CCDP serves entire families, but from the point of view of the evaluation we have to focus on a subset of participants, because there are so many family members, so many people in each family who are receiving CCDP services. Therefore, we focus on mothers. What we have done is measure a focus child and that child's mother. In nearly 98% of the cases, there is a mother available; sometimes it is a grandparent, a father, or a foster mother.

The questions we asked were 1) what are the effects of CCDP on maternal economic self-sufficiency, on income, receipt of federal benefits, and employment status; 2) how are mothers' parenting skills and the way they interact with their children; and 3) what are the effects on maternal reproductive health associated with the birth of subsequent children? There are also a series of secondary research questions about how these effects vary. Did they vary across subgroups of participants? Are they different for teen mothers or for mothers who were teens when they had their first child, as opposed to mothers who were not? Are they different for mothers who entered CCDP with a high school education versus mothers who did not? Are there differences for mothers who are living with a partner as opposed to mothers who are not? Are there variations when the child is male versus female?

Research, Demonstration, and Evaluation Branch Symposia

Another type of variation that we are particularly interested in is variation across sites. Clearly, we will present information about what the effect of CCDP is across everyone participating in the study, but there are 21 separate implementations of CCDP around the country. There is a lot of interest in whether the effects vary across those sites, and if so, how?

We are also looking at cost-benefit analyses. Our job includes an assessment of comparing costs against the benefits that families derive from being in the program. One difficulty for us is going to be that it is hard to put a cost amount on many of the outcomes that are being examined at this point. Clearly, if there were big effects on mothers' income or reductions in use of AFDC, it would be easier to measure because those have monetary equivalents. However, how do you assign a monetary value to a change on the Bailey Scale of Infant Development or on several other variables that do not have direct monetary translations?

Families have the opportunity to be in CCDP for five years. Obvious questions: Is more better; is less better; does it make a difference? We are interested in special studies and focusing particularly on teenage mothers and parenting education, one of the key elements of CCDP. We are trying to understand something about the links between parenting education, parenting attitudes and behaviors, and child outcomes. The hope is that parents will be able to change their attitudes and behaviors, translating into impacts on children.

The data that we have comes from 21 sites. There is a random assignment of families at each site, either to be in CCDP or not. There are about 200 families per site—100 treatment and 100 control. There is a total of 4,400 families—2,200 treatment and 2,200 control. The data were gathered from many measures administered to each family through face-to-face parent interviews, child testing, and observation of mother/child interactions. The plan was to measure families as children reached ages two, three, four, and five, with some interim interviews also. When data collection was completed, we had response rates at ages two, three, four, and five of 62%, 83%, 80%, and 70%. We ended up with about 4,000 families, out of the 4,400, whom we have measured at least once. This means that we were able to find 90% of the families. Of those 4,000, we have an average of 4.4 data-collection points per family. This data will be a publicly available database this fall or winter. It will be able to support interesting research beyond what we can do in this study and will be a resource for researchers.

There are two sets of analyses we will be doing. One depends on the nature of the data, and since we have a longitudinal data set with data collected at multiple points in time, there is the opportunity to look at growth over time. For example, data from the Peabody Picture Vocabulary Test or the Kaufman Assessment Battery for Children are available on children at three data points. We will be doing growth-curve analyses on those measures. Other outcomes that lend themselves to longitudinal analyses are some of the child's socioemotional measures. We used the Scott and Hogan Adaptive Behavior Scale and the Achenbach Child Development Checklist, where we have, again, multiple data points over time.

From an early look at the data, one can see that the PPVT and the Kaufman behave as one hopes they would, and that is that the control group children's scores grow over time. Looking at the socioemotional measures for the control group, we do not see growth over time on the Achenbach and the Scott and Hogan Adaptive Behavior Inventory. The Achenbach tries to measure traits as opposed to things that would change normally over time. We find that that makes sense.

We have multiple measures of maternal, economic self-sufficiency variables, such as receipt of federal benefits, AFDC, food stamps, WIC, Medicaid, job training, weekly wages, and sources of income. We are developing variables that look at steps to employment. Even if some-

Research, Demonstration, and Evaluation Branch Symposia

one is not working now, they may be in training, in preparation for work, or in vocational classes. We are trying to develop scales that provide options for answers, such as "not working," "on the path to working," or "working."

In terms of education, we want to know whether or not mothers have a high school diploma, a GED, a college or associate's degree, or are in a post-high school program. We also have measures of academic, parenting, and vocational class participation of mothers over the study period.

We want to know if the program has been able to affect incidence of low birthweight or of very low birthweight, premature delivery, or babies who need special care. Clearly, these variables could have big cost-benefit consequences. We have variables that look at whether or not the mother received late-term prenatal care, if there were serious problems with the pregnancy, or if the mothers smoked, drank, or used drugs during pregnancy.

Judy Jerald: For the last six years in our CCDP program in Brattleboro, VT, we have been systematically collecting what we consider to be very rich data. Each year we compile and analyze MIS data for our own local use. We are using this information for our program and for our community. The data we collect provide us with ongoing feedback that informs our practice. It helps us to let the families know about their accomplishments based on the goals that they themselves are setting. We also use the data to monitor the quality of the services that we are providing. We use it in staff supervision and as a tool for continuous program improvement.

Lastly, we use the information to help us with funding. Last winter our town said that they were no longer going to fund us. They said they had given us \$50,000 for each of the last nine years and now that we had \$1.6 million, we did not need their money any more. We went through a major campaign before a town meeting to let people know that we did need the money. My staff and I used a lot of our data to convince them that their funds were producing results. We used what we thought people wanted to hear. I heard someplace that Democrats like anecdotes and Republicans like statistics. We have a lot of Republicans in Vermont, and we gave them a lot of statistics. When the vote was taken in March, not one of the 140 representatives voted against funding us again.

I am not assuming any causation in the information I present. However, it is rich data and it is data that have come over time. I think it is clear that something was happening for the families as they participated in the CCDP program. I want to focus on two areas. One has to do with some changes in key elements of family development for CCDP families who were with the program for five years. The second area of focus is a recent study that we did that looks at 20 CCDP children who entered kindergarten last fall.

We started with the data analysis of 30 families who were with CCDP from its inception. We started with 61 families who were in the original Abt study as well, and 30 of those families participated for five years or more. Of those who left, seven left for employment elsewhere, six for improved housing, one to go to college, two moved when they got married, seven left for unknown reasons, and eight dropped out for lack of interest. Four of those eight dropped out within the first six months of the program. Every year in September we checked on the 30 families. We are heavily involved in employment and training since we have a state contract to implement welfare reform in our area for 45 families, many of whom are CCDP families as well.

We looked at all the significant adults who are contributing in the family. We saw that the second adult in that family was going to work. We think this was because CCDP was subsidizing child care. This is very important in terms of national policy. One of the things we noticed was

Research, Demonstration, and Evaluation Branch Symposia

that when families went to work there were more adults who ended up without health insurance. In other words, they were losing Medicaid and were taking jobs where they did not get insurance. That worried us for a couple of years. However, we see that decreasing now, and what may be happening is that as people stay in jobs longer, they are beginning to get benefits.

Education levels did not change very much, and a decrease in 1995 was due to a divorce; a well-educated person left the family. The number of our families receiving AFDC has decreased. There was an increase of 16% in the number of families with a car and 20% in families with a phone. We did a telephone interview with 27 control-group families once the program ended and found that they had fewer phones than when they started. That raises questions. One of the things we do is help with security deposits for housing and phones. Is that making a difference? We do not know, but it might be something to look at. We also saw a bell curve happening for families in subsidized housing; where once families were with us for a while, there were more of them in subsidized housing. They were also accessing services better. That also seems to be decreasing now.

One of the things that we are particularly proud of—and this is a rural issue and not something perhaps that cities would be looking at—is that nine of the families have bought or built their own homes. Programmatically, as we look at how we are providing services, we see we are heavily involved in housing issues. We are now looking at helping families get mortgages.

We were serving 54 CCDP families in 1990, 63 in 1993, 61 in 1994, and 57 in 1995. We see a trend, even for those families who were not with us all the way through: an increase in average earned income over time. This raises the question of how long is long enough. How long should we be serving families? This was a five-year project, and the current Early Head Start will be serving families for three years. It will be interesting to see if that will make a difference. Or does the start-up age make a real difference?

This fall we had 21 CCDP children entering kindergarten. We wanted to find out if the CCDP children were successfully competing or participating in kindergarten, and if so, what ways were they being successful, and if not, why not? Through teacher interviews we assessed the school readiness of the children, and then we compared that to the general population's school readiness as found in a preschool screening in the community. One limitation was that our sample was only 20 children. Another was that each teacher's perception differed in terms of what they considered to be the characteristics necessary for successful kindergarten experience. However, we tried to deal with that by asking the teachers: "What do you think are the characteristics of children who are ready to successfully participate in kindergarten?" There was a wide range, from nothing to being toilet trained. We then asked, "Based on this, would you say that this child is ready? What are his or her strengths? What are your concerns, and what can you do in your classroom to accommodate the needs of children who do not have the above characteristics?"

At one time we had a Follow Through program that worked with families and children, kindergarten through third grade. It bothers us that we are not getting into the schools and that the teachers are not hearing as much as we want them to hear about these children. This study told the teachers more about these children just because we were there asking questions. It heightened their level of interest about the children, and they were delighted to be asked these questions. Even though this might be considered an intervention, we think that is okay.

In a face-to-face interview with the teacher, and a survey with each teacher about each child, we asked questions about physical well-being, social confidence, language richness, emotional development, standards of appropriate conduct, general knowledge, and overall readiness. We went through the literature and identified 20 family and child risk factors that are correlated

Research, Demonstration, and Evaluation Branch Symposia

or associated with school failure. With the risk factors in mind, we gathered, through our MIS, child and family information about the 20 children. We found that 80%, or 16 children, were considered to be definitely ready or fine with a little help. There were four children, three of whom will need a lot of help, and one for whom there were serious concerns. That is 80% of a population of children who started out at risk in some way—at the very least, in terms of poverty. It seems that something positive was happening for these children.

It appears that families who were with the program for five years do better than those who were with the program for a shorter period of time. The families who receive significant mental health services during the time they are in the program might be doing a little better. It also seems that when families first came into the program, many of them were accessing emergency services or not very many services at all. The longer they were with us, the more involved they became in preventive services. Staff involvement increased dramatically, as did community agencies' involvement. Children we are studying now, who were born subsequent to the focus children, seem to be doing better than their older siblings. There are some clear indications, and our ethnographic studies address that, that there are positive changes in our communities as a result of the presence of a comprehensive, intensive, long-term program and that the community is actually taking over some of these services.

At Early Education Services we are very excited about data and research, and we are doing as much of it as we can without completely overwhelming our families and staff. Our next step is to involve parents more. We have just brought two of our parents onto our local research advisory committee.

Joan McLaughlin, *Abt Associates*: I will talk about the Cohort II evaluation. The Cohort I researchers are close to reporting on their findings, but we are just in midstream. Cohort I has 24 sites. In Cohort II there are 10. The programs in the evaluation were funded in 1992, and half are special-emphasis projects that focus specifically on families who were affected by alcohol or substance abuse.

The special emphasis sites are Philadelphia, PA; Proviso Township, IL; Springfield, IL; and two sites in Los Angeles, CA. One is at UCLA and focuses on alcohol abuse; the other is run by Shield for Families and deals with families involved in substance abuse. Our "regular" CCDP sites are in Greensboro, NC; Alton, IL; East St. Louis, IL; Cheney, WA; and Oakland, CA. Some of them are located in rural areas, such as Cheney, WA, while others are dealing with urban issues.

Abt was awarded a contract in the fall of 1993 to do both a process and an impact study for the Cohort II evaluation. For Cohort I we have two different organizations, and Abt is doing only the impact study. In the impact study we are interested in child and family outcomes—if the families have reached economic self-sufficiency, how they have done over their time in CCDP, and if the child's socioemotional and cognitive development has changed.

Families were randomly assigned to program and control groups. The sample size is smaller in Cohort II, about 2,400, and there were different requirements for the substance and alcohol abuse sites and the regular sites. The regular sites recruited 480 families, while the special emphasis sites recruited 240 families. In Cohort II we do home visits at the time of entry into the program and again on their one-year anniversary to see how families have changed during that time. We then go into the home again at the child's second, third, and fourth birthdays. The program was allowed to recruit families from the time when the child was in utero up to age one. Each of the sites had a different recruitment period, so we ended up having a little over three

Research, Demonstration, and Evaluation Branch Symposia

years' difference between the oldest and the youngest child in the study. The only implication of that is for data collection. We end up having to do many different things at once. That also means that we will not get all of our data until all of the children turn two. For the impact study, we have completed 96% of the first year after the enrollment home visit, seeing 74% of the two year olds in the families, 10% of the three year olds, and one or two of the four year olds. Overall our response rate has been about 89%.

At the same time, we have been doing the process study. The questions we have used to guide the process study component of the evaluation are: how is CCDP planned and implemented in each site; was CCDP implemented as planned, and if not, why not; what are the characteristics of CCDP program models, service delivery systems, and coordination arrangements; does the coordination among related programs increase the efficiency and effectiveness of services delivered; what accounts for differences in program impact? This is the part that links the process study to the impact study. If we see differences, we will be able to look back at the process study and see if we can determine what accounts for them. Also, ACYF and Congress are anxious to learn about the costs and cost-effectiveness of CCDP.

For information for the process study, we conduct site visits and use program documentation from the Management Information System (MIS). There are quarterly reports that each project sends to us, as well as to ACYF. Each site has their own MIS that they send to CSR and to us, and each site has an ethnographer who submits three reports annually.

Thus far in the process study, we have completed two site visits: an introductory site visit to introduce the study, meet staff, and find if there had been any changes since they had been awarded the grant; and a visit focusing on early program operations and talking almost exclusively with CCDP staff. We have two remaining site visits to plan. One this fall will focus on full implementation. Next year we would like to go back one more time, thinking of it as a policy trip. In this last round we would like to get their impression of what works in CCDP, what the barriers and the challenges were. Based on all of their experience running the programs, we want to ask them what they think people need to know when starting programs like CCDP.

For early program operations we focused on 1) start-up issues and issues about physical space; 2) staffing—planned and actual staffing patterns, recruitment, training, and retention of staff; 3) recruitment of families—what they planned to do and what they actually could do once they began looking for families; and 4) service delivery—core services, what is delivered, and how it is delivered. We also looked at the way that programs provided case management to families and the way that they provided early childhood education.

We did an analysis of the MIS to find out the characteristics of the program families for Cohort II CCDP. We used two sources for this information: a form that was filled out at the initial recruitment interview and a family profile, done once the family was enrolled in a program group. At program entry, the CCDP programs were 60% African American, 23% White, 13% Latino, and 2% each of Native Americans and Asians. These numbers compare with Head Start families as follows: 36% African American, 33% White, 24% Latino, 4% Native American, and 3% Asian or Pacific Islander—a little bit different from the CCDP families. However, for the most part, the projects have a predominance of one ethnic or racial group, with just a couple of exceptions to that.

On average, Cohort II CCDP families were made up of between three and four family members of all ages. More than half contained only one adult, and another third had two adults. Two percent of the homes—we presume these are the ones headed by teenage mothers—had no adults.

Research, Demonstration, and Evaluation Branch Symposia

We see that 33% of households had one child, 28% had two children, 19% had three children, and, at the time of program entry, 4% were pregnant and had no other children in the home. Across projects, 54% of the families had one preschooler, 43% had two to three preschoolers, and 3% had four to five preschoolers. In more than two thirds of the families, there was no father living in the household. The overall average masks enormous site differences—one site has 6% of fathers living in the household and one has 90%. The percentage of families where a single mother is the only adult in the household was 52%, but, again, it masks site differences. The site with 90% of the fathers living in a household has only 6% single-mother households, but the number is as high as 85% in another site. In the families who did not have a father living in the household, we wanted to know whether there was a grandmother present who would at least provide some support for the mother. We found that in 12% of the families, although no father was present, there was a grandmother to offer some kind of support.

When we looked at income we found that the CCDP families were among the poorest families in their community. The average yearly household income for CCDP families at the time that they entered the program was \$6,100 dollars. Fifty-five percent received below \$6,000/year, 26% received between \$6,000 and \$9,000, 13% between \$9,000 and \$12,000, and only 6% received over \$12,000/year. This is another point where we could compare our numbers to those families in Head Start. In Head Start, 43% receive under \$6,000/year and 18% are in the over-\$12,000 category. The other categories are roughly the same. These numbers indicate that Cohort II CCDP families seem a little bit poorer than the average Head Start family.

For almost two thirds of the families, public assistance (AFDC, SSI benefits, and other state or local assistance) was the only source of income. For another 10%, earned income was supplemented by public assistance. Eighteen percent derived income from employment only and four percent reported no income. We assume that these are the teenage mothers who are living with their parents. Another six percent patched together financial support from a variety of sources, including educational loans, child-support payments, and gifts from families. Across sites there was considerable variation in income derived from employment as opposed to public assistance.

Typically, when we talk about the primary caregiver in these projects, we are talking about mothers. There was, however, a very small percentage where it was a grandmother that was enrolled in the program. When we did these analyses we omitted the grandmothers.

The average age of the mothers at the time they entered the program was 23 and ranged from 13 to 44. This is interesting from the program perspective, because some projects have to deal with providing support and services to both very young and older people, sometimes a 30-year difference in age. The number of mothers who were teens at enrollment is 21%. Again, that varies by site from 2% up to 34%.

We are also interested in mothers who were teens when their first child was born, no matter what their age when they enrolled in the program. These women are likely to have less education, and so it may take more time and services to get on the road to economic self-sufficiency. The average age of mothers at the birth of their first child was 21 years. Forty-seven percent were 19 years old or younger, and 11% were 16 years old or younger. Seventeen percent of the mothers were married, living with their husband, and 17% were single, living with a partner. Fifty-six percent were single with no resident partner, and 10% reported that they were divorced, separated, or widowed.

More than half of the mothers had not completed high school and another 36% had ended their education after the 12th grade. Only 11% had educational experience beyond high school.

Research, Demonstration, and Evaluation Branch Symposia

The proportion of mothers who completed high school varied by site, ranging from about 13% up to 66%. We also were interested in the number of mothers who worked outside the home. We did not expect to see many that did, given that when they enrolled in the program they were still pregnant with their child or their child was still very young. Across all sites, 13% of the mothers were employed; this varied by site from 1% to 25%.

While an important part of the program's mission is to help families obtain assistance in the services they most need, a number of families were already receiving those services before they entered the program. More than two thirds across all sites were receiving AFDC benefits, and by site this ranged from 38% to 90%. For food stamps, across all sites it was 68%, with a range of 52% to 90%. Many more families still were receiving Medicaid benefits, 88% overall. In only one site did fewer than two thirds receive Medicaid. In five sites the average is 90% or more. For individual benefits, 80% overall were enrolled in the WIC project and in only two sites was it in the 50% range. Almost half the families received all four benefits. Again, this varied by site. About 6% received no benefits, but in one site it was as high as 27%; in others it was as low as 2%. Some families received energy assistance, child support, housing subsidies, and/or unemployment insurance.

Michael Lopez: We are doing a follow-up in five of the eight Cohort I sites. Civitan International, along with CSR, are the contractors who are helping us. We also have the support of the MacArthur Foundation. One of the research networks has a group of researchers who are contributing a \$2,000,000 add-on to our investment in another form of collaborative partnership, which will enhance what we are doing in three of the sites.

Audience Questions and Comments

Comment: First, I thought what Ed Zigler said this morning was really important—that Vicky Seitz, in her study, saw the most significant change in younger siblings. I hope that the follow-up studies focus on siblings that were born during the initial demonstration. Second, I would mention that these were empowerment models. We were really working with families to empower them. Therefore, the whole concept of empowerment has to be woven into the data that we examine.

Question: Are you doing a process evaluation on all 10 sites?

Answer: Yes. There were two sites that were funded in 1993: Birmingham, AL, and Spartanburg, SC, and they are not included in the evaluation.

Michael Lopez: Your comments illustrate the issue of partnerships with the local sites. This study is often very complex and overwhelming, and their insights have been instrumental in helping sort out some of the issues that are not apparent from the data or aren't apparent from the original design. There are a number of project staff who have made some incredible contributions to this effort over time. They may not have realized it at the time and they may have felt underutilized, but they have made a tremendous impact on our ability to actually conduct this evaluation.

■ Evaluation of Head Start Family Service and Head Start Family Child Care Demonstrations

Co-Chairs: Louisa Tarullo, James Griffin

Discussant: Shannon Tanaka

Presenters: James Griffin, Marjorie Levin, Bonnie Faddis, Paul Ryer

James Griffin: One of the questions that came up was why these two presentations are being grouped together. One reason is that they are both demonstrations. I want to underscore that, because of the value these types of program variations have in the role of Head Start as a national laboratory, and in our ability to evaluate them.

Both talks today are going to address a piece of the puzzle that has not received much attention; that is, life after the demonstration. What happens to these demonstrations when the program variation continues after the formal demonstration period is over? That is going to be one of the main foci of the talk by Marjorie Levin of Abt Associates on the Family Service Centers, whose funding continued even after the demonstration was over. It just became part of the regular Head Start grant. Another reason is that both demonstrations exemplify the value of the evaluations beyond the original hypotheses being tested. With the Family Service Centers, we had a model for implementing case management within Head Start and looking at what happens when you reduced the ratio of parents to Family Service workers. That is going to be relevant when it comes to welfare reform and the new role that Head Start will have in helping parents with issues that are very different from some that have been traditionally addressed by Head Start. With Family Child Care, there was a focus in the evaluation on measuring what the programs were doing, both in the centers and in the Family Child Care homes, and addressing the "black box" issue that we do not sometimes get at with our evaluations—what actually happened in the classroom or in the Family Child Care home?

Marjorie Levin: The Family Service Center (FSC) evaluation involved local evaluators. This presentation summarizes the effects of the integration of the Head Start Family Service Center on Head Start programs. When the demonstration ended for the Family Service Centers, the programs were granted indefinite funding to integrate the FSCs into the Head Start programs. Our contract was also modified to include a substudy of how these projects actually integrated into Head Start. This presentation will include highlights of our substudy, which was conducted to answer the question of what happens to the Head Start programs when the FSCs are integrated. Specifically, we looked at the integration process used by the Head Start programs, case management and the effects on case size, and how the different programs used different strategies to integrate services and staff. We also looked at changes in community collaborations and at the effects on Head Start programs of the FSC demonstration.

The FSC demonstration projects were funded by ACYF to enable Head Start to provide a more comprehensive set of services to address specific issues related to Head Start families. The projects were intended to build upon existing Head Start services, providing intensive case management to families and services in the three focal areas: literacy, employment, and substance-abuse prevention/intervention.

Since 1990 there have been 66 Family Service Centers funded. The projects were funded in three waves: Wave 1 (1990) with 13 projects; Wave 2 with an additional 28 projects (1991); and

BEST COPY AVAILABLE

Wave 3 with 25 projects (1991). All of the projects were originally funded for three years, with an average grant each year of about \$250,000.

In 1991, Abt Associates was awarded a contract to conduct a national evaluation of the Head Start Family Service Centers. The evaluation involved an experimental design. The primary objectives were to describe the services and activities of the Family Service Centers and to assess the impact of the FSCs on participating families. We are currently in the final year of our evaluation and in the process of completing the final report. Overall, the national evaluation found that the Family Service Centers had reduced caseload sizes, and participants in the FSCs had increased access to services in literacy, employment, and substance abuse. The centers were located in both urban and rural areas. The Head Start programs with Family Service Centers ranged from small rural programs with about 95 children enrolled to large urban programs with over 5,000 children. The Head Start programs with Family Service Centers averaged about 890 children. Most of the Family Service Center projects had seven or eight staff. In most of the projects, three or four were case managers. Some of the projects also had specialists in literacy, employment, or substance abuse. They may have acted as a resource for other FSC staff or they may have provided workshops and training in their specific area of expertise.

The FSC projects also had numerous collaborations with community agencies. Most of the FSCs had informal agreements with agencies providing services in literacy, employment, and substance abuse. The FSCs provided intensive case management, and the majority of FSC case managers met with families in person at least once a month, though many met more often. The case managers focused on personal issues and basic needs, along with services and needs in the areas of literacy, substance abuse, and unemployment. More than 75% of the Family Service Centers offered these services on site at the FSC, in addition to the services provided by collaborating agencies. Literacy services included adult basic education, GED preparation, family literacy, and tutoring. Unemployment services included pre-employment skills, skills assessment, and job placement. Some programs also offered internships or volunteer placements. Substance-abuse services included self-help groups, education and prevention workshops and trainings, and individual and family counseling.

Our study of the integration process included 61 of the Head Start programs that had Family Service Centers. Of the original 66 programs, 5 were not included because they had either been discontinued, were determined at risk during the time we were conducting the substudy, or were not given funds for integration. There was also one program in Los Angeles that served 1,000 families as part of the Weed and Seed initiative sponsored by DHHS. Our study included telephone calls to Head Start and Family Service Center administrators, as well as five site visits to programs where we spoke with program staff and community collaborators and observed some of the activities and services. Overall, we found that most of the programs reported a smooth transition when the FSCs were integrated into Head Start. Programs reported that they had planned carefully for the integration, and some had planned up to as much as a year prior to integrating. There were several programs that had also been integrated, but were still in the process of determining what was working and what was not. This was especially true for Wave 3 programs that had just begun integration as we were conducting the substudy. Most of the programs involved both staff as well as parents in the integration process, and all five sites that we visited involved the Parent Policy Council in integration discussions.

In talking with the programs, there were several factors that facilitated integration. One was involvement in the integration process. Program members felt that having everyone involved, knowing what was going on and how things were going to be changing, facilitated the integration

process. Another factor was staff training. This was needed in order to provide some of the newer FSC services to all Head Start families. Programs also reported that there were barriers to integration. One was an uncertainty about continued FSC funding before programs learned that the FSCs would continue to be funded. Several of the programs experienced staff turnover. In some cases they left to take permanent Head Start positions. In those cases, some of the projects were hesitant to hire new FSC staff, not knowing at the time whether or not the programs would be continued. Another barrier was a lack of program understanding on the part of Head Start staff and Family Service Center staff regarding differences in the programs. This led to apprehension about new roles and increased responsibilities once the Family Service Centers were integrated into Head Start. A last barrier was decreased resources for families and staff. There were many Family Service Centers that offered a number of resources to families that they worked with. There was one program that had a stipend of \$250 for each family to meet a need, whether that be child care or new tires for their car in order to get to work. There also were programs that had increased resources for staff, such as clinical supervision. When the programs were integrated and the resources had to be spread among more staff and families, some of the programs had to reduce services.

After speaking with all of the program administrators about the integration strategies they used, we categorized them into three models. Model 1 integrated all Family Service Center staff and services into Head Start. In other words, they made FSC services and staff a part of Head Start. All case managers were integrated, meaning that FSC case managers became Head Start Social Service staff and everyone had the same caseload. Caseloads were redistributed. All of the prior FSC services became available to all Head Start families. Model 2 was called Integration with Special Case Managers. These programs integrated the Family Service Centers but kept a part of the Family Service Center: some case managers with smaller caseloads. In most of these cases, all of the services were available to all Head Start families, but in some they maintained some separate services for the FSC families. Model 3 was a bit different. In these programs, they maintained the special case managers with lower caseloads, and in addition they provided special services to a subset of families. The FSC was viewed as a separate component within Head Start, so they chose families whom they considered to be in most need.

There were a variety of reasons why the programs chose the model of integration that they did. In almost all cases, it depended upon the needs of the program and the area, as well as the families. Some of the programs choosing Model 1, the general integration strategy, wanted to spread out the resources and reduce all caseload sizes for Head Start staff. Some programs using Model 2 and 3 felt that they wanted to provide special services to the neediest families. There were also differences among FSC case managers' levels of education and qualifications, and programs wanted to maintain these case managers in a special role with special responsibilities. These might be the case managers that were conducting groups or training programs. Another factor was the location of the Family Service Centers. Some of the larger programs located the FSC in one particular neighborhood or housing project, and they wanted to maintain the Family Service Center in that location rather than spread out the staff and services. Almost 70% of the programs chose Model 1. Eighteen percent of the programs chose Model 2, where they kept special case managers. About 13 programs chose Model 3, where they kept special case managers as well as special services for a subset of families.

An important piece of our study looked at the approach to case management and caseload size within Head Start. Programs reported that case management services within Head Start were usually provided by workers in the Social Services Component, but the approach varied among

programs. Some assigned Social Services workers, or case managers, to specific centers or small groups of families, whereas other programs had one Social Services Coordinator serving a large group of families, up to 200 or more. There were also programs that used a team approach, where sometimes they had a person with an MSW degree working with Family Services workers. There, they had a two-tiered approach to case management. The approach that the programs took affected caseload size, and caseload size we found was critical because it determined the type and amount of contact that staff could have with families. The average caseload size for Social Services staff was 75. A very small percentage had less than 20 families, and about 30% had 100 or more families. For the Family Service Centers, the caseload sizes were much smaller. Almost 32% had less than 20 families. About 2% had more than 60 families. The average caseload size for the Family Services workers was about 28 families. In many of the programs, the Head Start coordinators or other Head Start staff took on some of the responsibilities for services in literacy, employment, and substance abuse. For example, the Parent Involvement Coordinator might take on some of the responsibilities of providing employment workshops, or the Mental Health Coordinator might take on some of the responsibility for the substance abuse services.

The Family Service Centers also had staff specialists. In fact, during the demonstration more than half of the programs used a staff specialist in at least one area. This might have been a case manager with a special expertise in either literacy, employment, or substance abuse, or it might have been someone not part of the case management staff who would be conducting groups or acting as a resource for other staff in one of these areas. When the demonstration ended and the projects were integrated into Head Start, most of the programs continued to use specialists, but the distribution changed somewhat. There was a slight increase in the number of programs using literacy specialists and a slight decrease in the number of programs using substance-abuse specialists. There was also an increase in the number of programs using other types of specialists, and in most cases, we found that the "other specialists" included people such as family counselors or special mental health professionals. The reason for whether or not the programs continued to have specialists depended upon the needs of the programs and of the families. We found a program that had 13 sites with one employment specialist traveling between the sites. When the demonstration ended, they found that their Social Services workers in each of the sites were more familiar with employment services, and they could be trained to provide employment workshops and trainings for the families.

Our study also looked at collaborations with community agencies. Overall, programs reported that they maintained the relationships with community agencies that they had established during the demonstration. About half of the programs reported they were using the same agencies, but it is possible that these agencies were providing services to more Head Start families. About a third of the programs reported that their relationships had gotten stronger or expanded. They also increased the number and type of community collaborations due to expanding services to more sites or implementing new services. This was especially true in the area of mental health. One of the sites we had visited developed a unique relationship with a mental health agency. When the demonstration ended, this collaborator placed two agency staff on site at the Head Start. One of the agency staff became a Head Start case manager. Another agency staff member became a family therapist for all families in Head Start.

Overall, staff reported that the FSC integration had had very positive effects on their Head Start. One was an increased focus on the family. Staff felt that they were now able to better focus on the family as a unit rather than just on the children. Also, more services were being offered on site, especially in the areas of literacy, employment, and substance abuse. Another reported effect

was improved case management. The caseload sizes within Head Start were reduced as a result of the demonstration, and families were being provided with more and improved case management services. Another effect was more coordination among the Head Start components. As a result of the integration, many of the programs needed to restructure services and staff. Some of the Head Start coordinators took on responsibilities for some of the Family Service Center services. We also found more collaboration between case managers and coordinators, as well as between case managers and Head Start teachers. An increase in parent involvement and participation in services was another effect reported by programs. Another effect was a strengthening of community collaboration among the programs that had had the Family Service Centers. A final effect was increased visibility of Head Start in the community. Even when the demonstration ended, it continued to help improve the reputation of Head Start. Staff felt that they were more respected when they spoke at meetings and among different community groups.

In summary, Family Service Centers increase Head Start awareness and understanding of the case management practices and reduce caseload sizes. Family Service Centers also increased services provided by Head Start programs, especially in the areas of literacy, employment, and substance abuse. Head Start programs seemed to have had greatly benefited from the FSCs in terms of improved reputation and visibility within their communities.

We found that during the demonstration, many of the projects reported substance abuse as a particularly difficult area to identify and to provide services. The reasons for this are that families did not self-refer or talk about it during the needs assessment. One program spoke about the need for more training and awareness of Head Start staff in order to identify substance abuse issues in families. Some services identified as mental health services (i.e. self-esteem workshops or smoking cessation workshops) staff felt were actually related to substance abuse. A Head Start FSC program in Boston, where their focus is on substance abuse, made it an important part of their needs assessment. At enrollment, all families had to agree by their signature that if they were identified by staff as having a substance-abuse problem, they would participate in services or treatment.

Audience Questions and Comments

Comment: The other issue that needs to be dealt with is case management. In our program we had five staff for 40 families, so we had a one to eight ratio, whereas other programs have one case manager for 200 families.

Comment: In the project that we worked with, we had a specialist in literacy instruction and job training. They were not classified as case managers and they did not work with a set number of people, but they were also doing case management. They would often solve problems before people would come in and take literacy classes, and would work with them on a long-term basis. So the caseload might have been even lower had you included these specialists.

Marjorie Levin: Yes. We asked staff to identify who was providing the case management services. Some of the staff might have had a specialist who was also providing case management services, but they might have identified that person primarily as a staff specialist in one of the three areas.

Comment: I was a Director of a Head Start center and observed that my case managers were almost hesitant to identify substance abuse. The reason seemed to be that if you are a case manager involved with a family, and you are trying to make someone take the step to go into treatment, there has to be a treatment facility to accept them. You cannot just put them on a waiting list. We need to have immediate response strategies in place.

Louisa Tarullo: We are going to report on the Family Child Care Homes Demonstration project. Head Start has served as a national laboratory for testing and evaluating new methods of delivering comprehensive services to families, and when I hear this metaphor for Head Start, I get visions of test tubes and petri dishes, and it makes me think about exactly what it is we are hatching or growing. However, I think it is a useful metaphor for us to think about. When I think what exactly a laboratory is, I think of the idea that it is a place to test hypotheses and to place something interesting in a new medium and see what grows there.

The demonstration projects that we are highlighting today have been cultured in the laboratory of Head Start. They represent new and healthy developments that have grown up in the medium of Head Start programs. Although these demonstration projects themselves have come to an end, we are just now starting to learn the lessons that they have to teach us. Today we will be taking a look at the experiment of delivery of quality Head Start services through Family Child Care homes that have been designed to meet the needs of working parents by providing full-day Head Start services in a home-based setting.

We have heard a great deal at the conference about the changing demographics of the Head Start population. The Head Start Family Child Care Homes Demonstration Project is an example of an effort to be responsive to these changing demographics: the movement of families into the workplace. The conference theme is partnership, and this project has been a partnership like all of the others. I would like to acknowledge the contributions of Trellis Waxler, the Project Officer from the Head Start Bureau, and the Project Officers from ACYF RDE Branch: Mike Lopez, Martha Morehouse, who is now in ASPE, and Jim Griffin. It has been a pleasure to work with our colleagues from RMC: the Project Director Bonnie Faddis, Paul Ryer, and their partners at CSR Incorporated. Our technical work group included individuals who are leaders in the child care, family support, and child development fields. Most important to the success of the project, both the demonstration and the evaluation, are the Head Start practitioners and the families they serve, represented by Shannon Tanaka from the Oceanside, CA, Head Start program.

Although ACYF began funding Family Child Care homes under locally designed options and innovative projects in the mid-80s, the current project was launched through the Head Start Act. The Act called for a study of family day care to be done in compliance with the Program Performance Standards of Head Start. The focus was on both meeting the needs of this changing population of Head Start families and insuring the provision of a high-quality program.

The first goal of the demonstration project is to measure how feasible it is to provide services that meet Head Start Program Performance Standards in a family child care setting. The second goal is to describe how the family child care homes are implemented and operated and what the procedures are for making this happen within Head Start programs, and then to compare the quality of services that are provided in homes and centers. We will be reporting on various mechanisms for doing that using the Performance Standards, the on-site program review instrument used for monitoring Head Start programs, as well as other quality measures. Finally, and perhaps most important, the third goal is to compare child and parent outcomes between homes and centers, and to determine whether some children or families would benefit more from being

in a specific setting. There were 18 demonstration projects that were funded in 1992 for a three-year period. Following a start-up year, these projects agreed to serve two cohorts of 40 children each, randomly assigned to family child care homes or center-based services.

Bonnie Faddis: The criteria for families participating in the demonstration were meeting Head Start income requirements; having a four-year-old child (i.e., in the year prior to entering kindergarten); having parents either working or in school; and needing full-day care for their child. Since this was a demonstration study, parents needed to know that we were going to be collecting data about their family and evaluating their children. Therefore, they had to be willing to provide family background information and to have their child tested at the beginning and end of Head Start and during their kindergarten year. They had to be willing to have their child in either a family child care home or in a Head Start classroom setting, because they were going to be randomly assigned. As it turned out, even though parents agreed to this, not everyone got what they wanted in the random assignment, and there was some attrition because of that.

We collected the background data primarily through parent interviews that asked about family structure, race, ethnicity, primary language, parent education, employment status, child discipline practices, and so forth. We also looked at implementation characteristics: how the site implemented their family child care home program and what experience the agency already had in doing this. Two or three of the grantees had already provided some family child care as a locally-designed option; however, most of them did not have experience. We also looked at how they recruited families, made sure families got all of the component services, supervised and supported the family child care providers, managed all of the record-keeping requirements for Head Start in that setting, and what the costs were. This was done through interviews with the agency staff and with the caregivers themselves. In the area of comprehensiveness and quality of services, we looked at the Head Start Performance Standards as measured by the on-site program review instrument (OSPRI). Finally, we looked at effectiveness of services in terms of child and parent outcomes.

Today, the focus is on measures of program quality, how they are related to each other, and how they are related to the child outcome measures. We used the Peabody Picture Vocabulary Test, both in fall and spring of the Head Start year and again in the kindergarten follow-up, and an instrument called the Daberon II, which is a school readiness instrument. The Daberon II was given at all three data-collection points. We also used a measure of emergent literacy, "Concepts About Print," that looks at children's book handling, publishing knowledge, and such concepts as reading directionality. Teachers completed the Child Adaptive Behavior Inventory, a measure of social adjustment. During the Head Start year we used the High Scope Child Observation Record, administered by the teacher. We then had kindergarten teachers answer a questionnaire at the end of kindergarten to rate the child's readiness for kindergarten, the kind of progress they made, and parent involvement during the kindergarten year.

In our focus on quality, we used the Developmental Practices Inventory, modeled after NAEYC's developmentally appropriate practices for four and five year olds, and the Arnett Scale of Caregiver Behavior. We also conducted caregiver interviews with classroom teachers (i.e. comparison group children) and family child care providers. We had envisioned that within an agency all of the comparison group children would be in one or two classrooms. Unfortunately, that turned out not to be the case. Therefore, we ended up having quite a few more classrooms in our study than we had expected. In many cases, we had only one comparison group child in a classroom.

The goal was to have 720 children, 40 in each of the 18 sites that would be in the family child care homes and a comparison group of 720 children that would be in the classrooms. The number that were actually recruited exceeded that. We learned quickly, because not everyone who was recruited actually enrolled. We had more attrition in the family child care homes than we did in the center classrooms. Families wanted their child in a classroom, in a more school-like setting, prior to their entering kindergarten, even though they had made a prior agreement to either setting.

Paul Ryer: The two key questions that we are addressing today are 1) how do OSPRI scores relate with other measures of program quality such as the developmental appropriateness of the setting, caregiver qualities and behaviors, developmental appropriateness as measured by the DPI, caregiver behaviors as measured by the Arnett, and caregiver qualities as dealt with in the caregiver interview; and 2) how did those measures of quality relate to child outcomes—cognitive, socioemotional, and physical?

In the parent involvement area, there were significant differences between the two settings, with center-based superior to home-based. There could be two reasons for this finding. One explanation is that it is harder to do parent involvement in the family child care home setting, and another could have to do with the recordkeeping requirements and how one documents parent involvement. The family child care homes as a whole struggled more with the recordkeeping requirements necessary in Head Start.

We used other measures of program quality as well. The Developmental Practices Inventory (DPI) is based on the NAEYC standards for developmentally appropriate practices and programs serving children birth through eight. We focused on the four- and five-year-old section. There were significant differences on the developmental appropriateness scale at pretest and at posttest. What that says to me is that somehow the family child care homes gradually improved the quality of their program throughout the year. What it also says is that at the beginning of the year the centers were slightly more appropriate. However, if you look at just the score itself—the mean score—it really says that both homes and centers were in between “somewhat like this classroom” and “very much like this classroom” in terms of the amount of developmentally appropriate practice in the setting. This is a good finding, if you believe that developmentally appropriate practices lead to positive child outcomes.

The Arnett focuses specifically on caregiver behaviors. There are five factors. The first two are positive factors: attentive and encouraging. The last three: harsh, critical, and controlling and detached would be negative caregiver behaviors. Each factor is made up of three or four items. There were significant differences between settings on attentive and encouraging behaviors, with homes out-performing centers. This did not seem to make sense since centers were slightly more developmentally appropriate. However, family child care homes have a lower adult/child ratio, and this may enable care givers to provide more attentive and encouraging behaviors.

The OSPRI never has been validated as a measure of program quality. However, the education items of the OSPRI correlate moderately with the DPI and the Arnett: .54 and .53, respectively. What this may mean is that these two instruments are measuring similar constructs and that homes that score high on one are probably going to score high on the other. Therefore, the OSPRI might be used as a tool to measure program quality.

The “predictors” of child outcomes fell into three categories: child and family background, entering skill level, and program quality. Child and family background, gender, and mother’s educational level were significant predictors of literacy outcomes for children on a “concepts about

print" measure. The pretest of this measure was the most significant predictor, as you might expect. In addition, program quality, as measured by the OSPRI, was another significant predictor. This is important because that means that if you do well on the OSPRI, you get better outcomes on literacy development.

Bonnie Faddis: We did some follow-up phone interviews after the Demonstration Projects were completed to see how many agencies were able to continue doing family child care using their regular program funds, how they felt about it, and whether they were planning to continue it next year. We were surprised to learn that 10 of the 18 were able to continue offering family child care as an option. For those that did not, the primary reason given was not wanting to take funds away from their classroom budget to provide family child care. Several of those hoped to offer it again at some point in the future if they had expansion money or additional funds. Others felt that they did want to offer family child care again because it had been successful for them. Therefore, there are a total of 39 homes, serving 190 children, this year that are still offering family child care. Since it was no longer a demonstration project, they were able to open homes to three year olds.

One of the issues we looked at during the demonstration was whether the family child care providers were regular Head Start employees or independent contractors. During the demonstration, most of them were independent contractors. Most of the agencies ran into problems with unions if they tried to hire them as employees, because the operating days had to be longer than eight hours for family child care. That continued past the demonstration, although of the 10 that continued, we had 4 that hired the providers as employees. Most were paid per child slot, ranging from \$19 dollars a day per child to \$25 a day per child. A few, who tended to be employees, paid the providers an hourly rate. Most of the homes were open 10 hours per day, with a range of 7 to 12 hours. About half of them had the homes open year-round; the other half operated during the school year or for a 10- or 11-month program.

We also asked about supervision. About half of the programs still had a Family Child Care Coordinator. In other cases it was a duty assigned to the Parent Involvement Coordinator, the Education Coordinator, or the Disabilities Coordinator.

Shannon Tanaka, Education Specialist, MAC Project Head Start, North San Diego County, CA: MAC Project Head Start is an agency that presently serves 681 children from rural and urban areas. We have a total of 12 centers; two provide all-day care for families, one operates during the program year and one is year-round. We also have four family child care providers offering year-round services to 21 children. It was challenging, exciting, exhilarating, and frustrating to be part of the Family Child Care Demonstration Project. Ultimately it was lasting and worthwhile and it worked for us. For providers, we collaborated with the San Diego County Family Day Care Association. They were contract providers as opposed to Head Start union staff. Initially, we used the state licensing regulations for provider qualifications, but they presented a problem with recruitment of bilingual providers. The population that we serve is approximately 75% Latino, and 65% of our families speak Spanish as their primary language. Out of eight providers we recruited, only one was bilingual. We have improved since then and we now have two. The language barrier was a struggle. It was only due to our Social Services Coordinator and her staff who are bilingual that we overcame that barrier, because they were willing to go out to the homes, talk with the families and the children, or telephone the families.

Looking back, we feel we should have placed our providers in the greatest area of service need. Instead we tried to reach everyone. That made it difficult to monitor the program, and I could not always provide optimum monitoring (i.e., on a weekly basis), or provide the technical assistance that the providers needed. One solution was to give fax machines to all the providers and that helped with communication.

The Social Services Coordinator and her staff, after being fully trained, were key in the recruitment of families for the program. We asked them to be honest with the families and not promise them something that we could not deliver. That was very important in terms of random assignment in the center or home-based program. However, it still was difficult when the families were told of their placement and it was not the placement they wanted. We found that to keep the numbers stable and to stay as close as possible to 80 children, we had to continue to recruit throughout the program year. Between the time of recruitment and the time of enrollment, we lost families for a variety of reasons, such as moving out of the service area, needing care for siblings that we could not provide, needing other than nine-to-five care for their child, or having transportation problems.

Parent involvement had to be looked at in a different way. Some key site supervisors helped in this area by talking to parents and making them feel welcome, not only in the homes, but also at the centers. Some families were part of our Policy Council. We invited parents to stop by in the morning, if they had extra time, to have breakfast with their child and the provider. The parents who were in school or a training program had more flexibility, and they could spend more time with their child. When we started, we had providers and some parents, too, who were uncomfortable with that. The provider looked at it as, "This is my home, my place of business." The parents sometimes looked at it as, "This is not quite a center; I am not sure I should be here." Eventually, however, they became more comfortable with each other and established good relationships, although this did not happen for everyone in every family child care home.

In the first year of services, there was confusion about how the family child care home should look. We did not know if it should be a mini-center or just a home-like setting. Eventually things evolved into a workable combination. We integrated the center aspects that worked in the home with the providers' preferences, the space in their home, and the design of their home.

In 1994 and 1995, our Policy Council and the staff assessed the capacity of our Head Start program to provide full-day services. The result was that they all wanted to keep the family child care homes. We had proven that we could deliver the services, that we were doing a good job, and that it was a good model that allowed for some parental choice. It also was a good option for children who did not thrive in a larger setting. It was a more personalized way of providing family support and strengthening the families while helping them to work, attend training or school, and move towards self-sufficiency.

Through funding from ACF Region IX, we have retained three of our original eight providers, and we have added one more provider who has Head Start and special needs experience. Presently, three of the four homes are accredited nationally.

Research, Demonstration, and Evaluation Branch Symposia

Audience Questions and Comments

Question: I have two questions about parent involvement. First, did the grantees feel that each Family Child Care home should have a parent committee in order to comply with the Performance Standards and, therefore, have Family Child Care providers organize parent activities for that specific home? Second, in looking at parent involvement, did you have some kind of measure for what goes on in the interaction as parents drop off and pick up their children?

Paul Ryer: They tried to integrate their parent involvement with a sister center or among the homes as a whole. They did not treat each home as an entity, but the homes that tended not to succeed did not look outside themselves for parent involvement support. In terms of measuring parent involvement, we did count informal interactions. In the FCC homes, there were twice as many informal interactions among the caregivers and parents. That could offset any deficiencies that homes had in parent involvement.

Comment: I was wondering about serving children with disabilities in the home. You said one provider had training in special needs.

Shannon Tanaka: We have a Special Needs Coordinator. The majority of our children's special needs are speech-related. That made it somewhat easier. Also, we have special-needs teachers and aides who went into the homes and provided assistance just as they did in the centers. They also were available to transport children for services because we have an agreement with the school district to provide those services.

■ Descriptive Studies of Head Start Bilingual/Multicultural Services Population and the Migrant Head Start Program

Co-Chairs: Henry Doan, Michael Lopez

Presenters: Patricia Hamilton, Anne Steirman, Ed Kissam

Michael Lopez: This afternoon we have two complementary studies that pick up on Sir Michael Rutter's presentation on risk and resiliency. We will look at strengths of populations of children and families, as well as the programs that provide services to these families.

The first study is on the characteristics of families served by the Head Start Migrant program. The origins of the Head Start Migrant program go back to 1969, when Congress mandated that the Migrant and Indian Head Start programs be administered at the national level. Until then, Head Start services were generally unavailable or inaccessible to migrants due to their work schedules. Therefore, the uniqueness of these two populations required some special consideration for the way that the programs were administered. In the spring of 1984, the Indian and Migrant Programs Division was reorganized as two separate branches funded and monitored directly from Washington, D.C. By 1990, Migrant Head Start was providing services to approximately 23,500 children from ages zero through five, 35% of them infants and toddlers.

The Migrant Head Start program is one of the more comprehensive ways in which Head Start has been providing services to infants and toddlers. Serving infants and toddlers is quite different from providing services to preschool-age children. Some special issues are staff/child ratios, services, and transportation. The new Early Head Start initiative can learn about providing services to infants and toddlers from their colleagues in the Migrant Head Start program.

In addition to poverty and seasonal employment, migrant families often have lower educational levels, inadequate housing, transportation difficulties, and more difficulties with the availability and accessibility of child care, health care, child and family services, and social, nutritional, and legal services. The range of services that most Head Start programs provide are even more difficult to provide given a variety of issues, including the rural status of many of these programs. Within this unique context—keeping the mobility factor in mind—Migrant Head Start grantees have developed very creative program designs. It is an amazing feat to put together programs and provide services when you do not have the luxury of knowing when a particular service period starts. For example, it would be nice if every September 1st a program would open and run for nine months and then close. None of that applies in the Migrant Head Start program.

In 1992, we implemented a study because we did not know enough about the Migrant Head Start program, the population we were serving, and the eligible population that we were not serving. The purpose of the study was to document and describe the implementation of the 26 current Head Start Migrant programs. This descriptive study will provide a profile of Head Start migrant families in the main migratory streams and generate information on unique issues related to serving migrant families through Head Start programs. The study also will document the availability and coordination of services for Head Start families during their migration and provide a national estimate of the number of children of migrant farm workers who are eligible for Head Start services versus those who are currently being served.

The data sources from this study include Migrant Head Start grantee directors, staff, and parents, children's health records, state and local agencies, and associations that provide services to the Migrant Head Start families, grantee applications, and OSPRI reviews. There are a variety of national databases containing information on the migrant population. The findings of the study, we hope, will be used by the Head Start Bureau to determine the extent to which the Migrant

Research, Demonstration, and Evaluation Branch Symposia

Head Start program is serving eligible migrant families throughout the country, and to gain a better understanding of the characteristics of these families. We will also use the information to plan future Head Start expansions and as another source of information and input for the new Early Head Start grantees.

Anne Steirman: The study was developed to address three objectives:

1. To characterize the current Migrant Head Start client population. The Migrant Programs Branch of the Head Start Bureau is interested in information on the migrant farm worker families who travel with their young children and who use the Migrant Head Start services as they travel.
2. To provide an overall description of the Migrant Head Start delivery system and to document the availability and coordination of services related to serving Migrant Head Start families. Some of the issues addressed under this objective include families' access to social services and provision of health care services.
3. To estimate the need for Migrant Head Start services and to estimate the proportion of families currently being served by the Migrant Head Start program.

Within Migrant Head Start a grantee may serve an entire state, such as the Migrant and Indian Coalition in Oregon, or a grantee may serve one or two counties, as in California, where eight grantees operate centers in their own regions of the state. Grantees may also contract with delegate agencies, which also may be community-based organizations, government agencies, or educational institutions, to operate the centers. Delegate agencies often are used to operate centers in a local area in cases where grantees serve a large geographic region. For example, the East Coast Migrant Head Start project, whose grantee offices are located in Arlington, VA, uses 22 different delegate agencies to serve migrant children in 12 states.

Our data-collection activities were conducted between June 1994 and April 1995. Prior to that time we needed to determine from whom data would be collected. The main requirement was that we visit all of the funded grantees. At the time that we began collecting data there were 26 grantees funded to provide Migrant Head Start services in 38 states. Thus, we began with the survey instrument for the director of the 26 grantees. Then, working closely with the statistician, it was determined that we would need to survey a minimum of 1,000 families who were enrolled in the Migrant Head Start program in order to have a statistically valid sample size. It was determined that we would not sample from the parent/child centers or from the families enrolled in a home-based center. This gave us approximately 300 centers from which to sample. We categorized each center as a summer or a winter center. Some of these summer centers were open for as few as six weeks because that was when the migrants were in the area. The sample was approximately 65% to 70% of the summer centers and 30% to 35% of the winter centers, although approximately half of the children, or about 500, were to be sampled in each season.

In determining the number of centers to sample from, the number of centers per grantee was considered. Some of the larger grantees, such as the East Coast Migrant Head Start project mentioned earlier, and the Texas Migrant Council, warranted a large number of centers being included in the sample in order to adequately reflect the diversity of the populations they serve. The number of centers agreed upon to maximize generalizability, yet remain within time and budget constraints, was 81: 53 in the summer cycle and 28 in the winter cycle. A survey instrument was designed to collect information from the director of each of these 81 centers. In cases where

Research, Demonstration, and Evaluation Branch Symposia

the selected centers were administered by a delegate agency, the director of the delegate agency was interviewed using the same survey instrument.

In addition to individuals directly affiliated with Migrant Head Start, we were interested in speaking with individuals in the social service agencies that collaborated with the Migrant Head Start programs. Agencies were selected for interviews based upon the type of agency they represented, such as health, community-based, job training, social services, or education. They were also selected for their geographic service areas. Through telephone interviews we spoke with representatives of 99 social service agencies.

Parents to be interviewed were selected from the center roster in a predetermined manner based upon the number of children enrolled at the time of the site visit. For example, in a center of 30 children, every third child was selected. In the largest center in our sample, which had 323 children, every ninth child was selected off the roster. Specific methods for selecting additional parents were applied in cases where the selected parents declined to participate. Our goal of a minimum of 1,000 parent interviews was achieved by reaching 1,014 interviews in our eight-month data-collection period. In addition, in conjunction with the study being conducted by CDM on the Head Start Health Component, we conducted reviews on the health records of 1,022 children, most of whose parents were interviewed for the study.

The overwhelming majority of families enrolled in the Migrant Head Start program considered themselves to be Hispanic or Mexican. Ninety percent of the families were two-parent families. Fewer than half of the parents spoke English well or somewhat well, and less than 20% of the parents had graduated from high school. This proportion varies dramatically when looking at the location of schooling. Of parents who were schooled in the United States, approximately 30% were high school graduates, while only 8% of parents who attended school in another country graduated from high school. We also examined employment patterns over the previous year and determined whether parents were working full time, which was more than 184 days in the past year; part time, which was fewer than 184 days in the past year; or not at all. We found that in 55% of the families, both parents were working full time although not necessarily both in farm labor. A full 73% of the families had both parents working at least part time. In 14% of the families, only the father worked, and in 10% of the families only the mother worked. This 10% of families where only the mother worked most likely corresponds to those 10% of families that were headed by a single mother.

Further analyses on the families indicated that their family size and incomes kept them well below the poverty level. With regard to their migrancy, two thirds of the families who participate in the Migrant Head Start program move one or two times each year. As few as 10% of the families make three or more moves each year. Information on migration patterns showed that about 40% of the families considered their home bases to be in the Midwest or the West, and about 20% considered their home base to be in the East. For the 8% of families who considered their home bases to be abroad, the majority of those were in Mexico, which we considered to be part of the western stream. We also found that approximately 90% of all families stay within one of the migrant streams, indicating that they generally travel north and south in search of work rather than east and west.

Centers are not always able to enroll all of the children who apply for admission to the Migrant Head Start program right away. Each center or grantee develops its own set of criteria for selecting children for enrollment when there are more children than slots.

Migrant Head Start played a significant role in insuring that children receive routine health care services. According to parents' reports, the proportion of children who receive services, such

Research, Demonstration, and Evaluation Branch Symposia

as routine physical examinations, immunizations, and vision, hearing, and dental exams through the Migrant Head Start centers was significantly larger than the proportion for whom services were secured by their parents. The role of Migrant Head Start in assuring that preschool children receive screenings for hearing and tuberculosis and dental examinations deserves special note because migrant children definitely are at risk in these areas. Another area in which Migrant Head Start endeavors to play a role is in empowering parents to seek out their own services. However, we do not know if the Migrant Head Start program had an impact on those parents who sought medical services on their own.

Children's health records were examined to determine the immunization status of the children enrolled in the Migrant Head Start program. Immunization records were compared against the requirements specified by the Head Start PIR, that by the time children are four to six years old they should have received four DPT, three polio, and one measles or MMR vaccine. The more stringent Head Start program performance standards requirement implemented in 1994 specified that children receive five DPT, four polio, and one MMR vaccine. Our review showed that nearly all children age four years and older had received the 4, 3, 1 immunization series. Furthermore, a substantial proportion had met the 5, 4, 1 requirement, even though those requirements were just taking effect at the time that data were being collected.

Many Migrant Head Start centers recognize that parent involvement is a difficult task since both parents in 55% of migrant families work full time, and they often work long hours, especially during peak harvest seasons. In three-quarters of the families, at the time of the interview, at least one parent was involved in the Migrant Head Start center in which their child was enrolled. Activities in which parents were most often involved were volunteering in the classroom, serving on the parent policy council, assisting at open house, or helping in the center's kitchen. Some of the reasons given by parents for getting involved in their children's centers were that it allowed them to have input into their children's program, they enjoyed the activities, it provided them the opportunity to learn new things, and it allowed them to socialize with other parents. Only 5% of the parents said that they participated because it was required.

Parent education activities are another core component in the Head Start program model. Investments in parent education make it possible for parents to be more actively involved in their children's education, as well as help them overcome skill deficits that may limit their employment opportunities. Many centers offer instruction in the areas that they feel parents are most in need. More than half of the centers offered or arranged with collaborating organizations for instruction in child development, parenting, health and nutrition, English as a second language, GED preparation, or literacy and basic skills.

Interagency collaboration is necessary to implement the Head Start model of integrated services to families in rural areas of the United States where social and health program resources are very limited. The predominant mode of collaboration is referral of families by the Migrant Head Start centers to the collaborating agencies. Many of the Migrant Head Start centers also provide services to facilitate families' access to services. These efforts include providing transportation to other agencies' offices, assistance in filling out forms, translation, and presentations on available services. Many agencies have developed resource guides for the Migrant Head Start families, listing available services and contacts. In the West and Midwest, bilingual and bicultural services are commonly available at these agencies. Center directors noted, however, that problems still remain in such areas as availability of services and determination of families' eligibility for services.

In addition to providing the quantitative information regarding their participation in Migrant Head Start, parents were also asked for qualitative feedback about their experiences with

the program. While Migrant Head Start has configured its operations to serve working migrant families, the reason given by the majority of parents for enrolling their children in the program was to prepare them for a school education. This indicates that migrant parents view Migrant Head Start not just as a day care provider, but clearly as a provider of educational experiences. The second most common reason given by nearly half of the parents was a more practical one: it allowed parents to work. This observation was important for welfare reform as it indicates that parents are ready to work, but that they need the services provided by such programs in Head Start to enable them to do so. When parents were asked what they felt were the best features of the Migrant Head Start center where their children were enrolled, the majority responded that they appreciated the learning opportunities available for their children, as well as the good care the children received while in the centers. Issues of nutritious food or provision of health care, while integral to the overall Head Start experience, were not necessarily the things that parents liked best about the program.

Ed KISSAM: I want to talk about some of the implications of our initial findings for the future, in terms of practical policy and practical program design issues. From the study, we found implications for planning and for future research, which ultimately will relate to yet another cycle of planning. Even though the Migrant Head Start and the overall Head Start program model continue to be viewed as one of the most valuable social program investments in the country, there are new issues that will play out in the context of welfare reform, decentralization, and the health care delivery system. Whether or not those changes are justified from a policy point of view or not, what is almost inevitable is that the changes—be they ultimately valuable ones or not—will destabilize these existing, somewhat fragile networks to some degree.

We need to pay attention to the immediate service delivery challenges. The first of those is preserving existing service delivery networks and developing more. Tuberculosis screening is important in the context of farm worker housing becoming increasingly crowded and dilapidated. In talking to center directors, it becomes clear that additional attention will need to be given to collaboration in community mental health services because many providers are concerned about the possibly increasing levels of domestic violence, substance abuse, and HIV infection, all of which are issues that have not been given full attention in rural areas.

In terms of collaboration, Migrant Head Start programs do not, and cannot, provide services on their own without health service providers, adult education providers, employment training providers, and a variety of farm worker advocacy programs.

The other immediate challenge is rebuilding the original Head Start vision of integrated family services. This includes several program design challenges. The first is full-spectrum family assessment. Migrant Head Start grantees use standard Head Start assessment instruments; however, not all of the grantees currently are doing a full spectrum of family assessment. That kind of family assessment will become increasingly necessary and useful as the stresses on farm worker families increase. One of the environmental realities is that farm worker wages are continuing to decrease in terms of real earning power and farm worker employment is continuing to become more destabilized. Obviously, the corollary to full-spectrum family assessment is full-spectrum support services. What we heard from many providers was the need for case management services and problem-solving help to families dealing with the incredible complexities of social service access, given their low literacy and educational levels.

The final program design challenge is whole family learning programs. Certainly, some centers and grantees are exploring those. For example, in California there is a promising model

Research, Demonstration, and Evaluation Branch Symposia

called Family English Literacy Programs, which is a version of the overall Even Start model and essentially involves the entire family in learning together.

Even though there are challenges, there are opportunities. The first is to strengthen private sector linkages to work with agricultural employers and other businesses in rural communities. The second is in service articulation. There are new opportunities to articulate services to better respond to the conditions during the summer when families are harvesting and in the winter when they have more time on their hands. There are also some challenges and opportunities for long-term collaboration. The first is to improve farm worker housing. In the cases where housing is available, it has been shown to be a marvelous locus for service delivery. There is some opportunity to leverage private sector resources from agricultural employers and businesses in rural areas. Another challenge is fostering multiculturalism. That means going beyond biculturalism to cultural pluralism.

Finally, our challenge is preparing children for the twenty-first century information society. Early childhood is not too early to begin preparing to avoid a future of information haves and have-nots. The first opportunity is building community and empowering families. Migrant circuits are pretty predictable, and it is possible to set up good service linkages around these circuits. The second is to extend Head Start beyond the classroom with full-family learning options; for example, self-help housing projects. The third is to foster proactive community involvement. The reality continues to be that farm worker migrants are isolated socially, racially, or economically from the rest of the communities in which they live. Proactively, information technology can be used to streamline migrants' cumbersome eligibility determination, particularly for a population not immensely used to record keeping.

There are new directions for research that are tremendously promising. The first research question is to look more extensively at the relationship and causal links between migrancy and educational disadvantage. There is some evidence that disadvantaged families do migrate more than families who have better social capital. The second question is whether the relationship between migration and educational disadvantage is linear. There is growing information from educational researchers such as the Suares Arrozcos and Ruben Rumbau that immigrant children's educational experience in the United States gets worse with time. How can we try to get better outcomes over time in the U.S.? Are the problems due not to acculturation per se, but to lack of support for the acculturation process? What other extraneous factors affect migrant children's educational outcomes? One of the difficulties of using migrants as a research population is that their experiences are tremendously diverse. Finally, understanding Head Start program impacts better involves research on which factors affect family well-being, to what extent positive impacts are a result of family strengthening, whether initial positive impacts are sustained, and if so, what factors are associated with greater impact.

Henry Doan, Research, Demonstration and Evaluation Branch at ACYF: It is everyone's perception that the U.S. population has become more diverse during the past 30 years. This is confirmed in the last three U.S. censuses. There are now more children and families of bilingual and multicultural backgrounds than ever before. Head Start programs from many parts of the country have been serving more children and families of diverse backgrounds and have become very innovative in meeting the needs of the children and families. At the national level we would like to document those innovations in the hope that the experience can be shared, successful program services duplicated, and mistakes avoided. Therefore, toward the end of 1993 we awarded a contract for a

Research, Demonstration, and Evaluation Branch Symposia

duplicated, and mistakes avoided. Therefore, toward the end of 1993 we awarded a contract for a descriptive study of Head Start bilingual and multicultural program services to STRA Incorporated and the subcontractor, Juarez.

There are four main objectives of the study: 1) to determine the bilingual and multicultural population eligible for Head Start; 2) to describe the populations currently being served by Head Start; 3) to determine how services are provided to bilingual and multicultural families; and 4) to document bilingual and multicultural features of Head Start programs. The contractor conducted a national survey of all Head Start programs in the nation, and, from the results of the survey, we selected 30 programs for in-depth studies, site visits, observations, and ethnographic studies. Dr. Pat Hamilton, the project director, will be presenting the preliminary findings.

Patricia Hamilton: I will briefly describe the methodology employed in this descriptive study, and then highlight some of the major findings. In the study, when I talk about a program I am talking about a grantee or a delegate, and when I talk about a center I am talking about a building that has one or more classrooms in it. Our bilingual service we define as the use of a language other than English in the provision of services to Head Start children and families. Our multicultural service is defined as the use of materials or methods that reflect, and are sensitive to, the ethnic, racial, and cultural heritage of children in Head Start. Bilingual children speak a language at home other than English, and multicultural children come from racial or ethnic groups outside the dominant Eurocentric culture.

Following the literature review and study design, we conducted three interrelated data-collection and analysis activities: the census and PIR analysis, development and distribution of a survey, and on-site visits. We analyzed the 1990 census using the Public Use Microdata sample, which is a sample of the 5% of the population that fills out long forms and compared that with a Program Information Report (PIR). This data was used to determine the characteristics of the Head Start-eligible and served populations. We also looked at trends. We looked at the geographic distribution, both by region and by state, and we looked at ethnicity and home language. The survey was sent to all 2,006 grantees and delegates to describe the populations served and to determine the range of services available to the bilingual and multicultural children and families. The survey was completed by the Head Start Director or his or her designee, and like the PIR, uses the Head Start program rather than the center as the unit of analysis.

A subpopulation of 100 of the most multicultural and multilingual programs was selected to receive a longer survey, which we called Survey 2. We asked more in-depth and open-ended questions regarding obstacles, solutions, and delivering services for different ethnic and linguistic groups.

The site visits were done by a team of two researchers over three days to gather qualitative data on services designed to meet the needs of the diverse groups. Principal among the site selection criteria was linguistic and cultural diversity. We also wanted diversity in the size of the program, area of the country, agency type, and number of languages spoken.

In terms of population increases over the last 30 years, the Asian/Pacific Islander group increased from almost one million in 1960 to eight million in 1990, an increase of 800%. On the other hand, the Latino population increased from 9 million to 24 million, or 166%. The African American population increased from 19 million to 30 million, or 61%. The American Indian/Alaskan Native increased from about half a million to almost two million. The White, non-Latino group increased 20%, from 160 to 191 million.

Research, Demonstration, and Evaluation Branch Symposia

We know that Head Start does not serve all eligible children, but in the 1992-1993 school year they served 45% of the eligible children, and in some years it goes down to 35%. We also know that the majority of the children that were served are racially and ethnically diverse. Head Start's population is 36% African American, 24% Latino, 3% Asian, 4% American Indian, and 33% White. Two out of every three eligible American Indian children, 60% of eligible African Americans, slightly under half of the eligible Asian and Latino children, and one out of every three eligible White children are served. Fortunately, the staff is also diverse. Survey data, rather than the PIR data, was used because the PIR does not collect data on staff. The aggregate data shows that ethnically the staff are fairly comparable to the population served, except that there are more White staff than White children.

We also know that there are over 140 languages spoken by Head Start families. Fortunately, there are also 100 languages spoken by Head Start staff. About 130,000 children whose first language is not English are in Head Start. There about 36,000 staff who speak another language in addition to English. Seventy-four percent of all Head Start programs have children who speak a language other than English. Only 26% have only one language, and that language is generally English. There are, however, over 300 programs where the majority of the languages spoken are not English. Most of those are Spanish, but there are some Arabic and Chinese programs.

When we did site visits we found that programs tended to have multicultural approaches that fell into three categories: the tourist approach, the culture-centric approach and the appreciation-for-all-cultures approach. The tourist approach usually has somewhat of a pejorative connotation and is characterized by posters on the walls and people in traditional costumes. They celebrate well known cultural holidays, such as Cinco de Mayo. They have books and music depicting various cultures and ethnicities, but do not seem to incorporate this multiculturalism into their day-to-day activities.

The culture-centric programs focus on the culture and/or ethnicity of the children and families in the program. They have books and music, they celebrate holidays, and they have dress-up clothes. Parents and community members come in and share their traditions. They also have staff that represent the cultures served. They do not, however, reach beyond their own people. This was found more frequently in African-American programs.

The third group has an appreciation for all cultures. Children are taught about all cultures because it is important for peace and harmony in the world, and children need to understand, appreciate, and value cultural diversity. They celebrate holidays and have books, music, dress-up clothes, and parent involvement. Additionally, they focus on hiring staff who represent their cultures. In addition, as the populations change, they try to adapt to these changes by buying multicultural materials, conducting self-development trainings, and trying to hire bilingual staff, translators, or by opening new centers. Although almost all programs had multicultural materials such as music, books, dolls, posters, food, and clothes, it is significant that very few used a multicultural curriculum.

Almost all the programs translate materials or get them translated, mostly into Spanish, followed by Vietnamese, Hmong, and Chinese. It was much easier for programs to translate into Spanish than other languages. Those translated materials included forms such as enrollment forms, recruitment information, Head Start information, and information they need to get to parents in the form of letters, newsletters, and posters. Administrators, both in the survey and in the site visits, wanted to hire bilingual and multicultural staff but had great difficulty finding people who were literate in their own language and in English.

In the classroom, we found that children tended to associate with other children within their own linguistic group. If all the children spoke English fluently and their home language was primarily English, it did not matter if they were Latino, African American, or White—they played together equally. When bilingual children interacted with others in their language group we also observed that they tended to switch between their home language and English. When a classroom lacked bilingual staff, the teachers and aides attempted to communicate with the children by memorizing certain phrases, generally command phrases such as “come here,” “sit down,” “do not leave,” and “right.”

We interviewed all coordinators, directors, teachers, and aides in the classrooms we observed. We conducted focus groups with parents and also attempted to observe other component activities. We went on doctors visits and on the bus to pick children up or take them home. The parents in the focus groups were self-selected, so they were very positive and really wanted to present their Head Start program in the best light. They were eloquent in their tales of what the program had done, not only for their children and themselves, but for their whole families. Most of the programs were half day, and they wanted longer class hours and summer programs. Most people felt very proud that they were asked to come into the classroom and share their traditions and cultures. However, the majority of immigrant parents stated firmly that they wanted their children to learn and to speak only English, because English was the language that was going to assure the children's success in school. The teachers and staff were frustrated because they were all sold on the advantage of bilingualism and knew something about the research that says the children should become fluent in their home language, and the dangers of familial communication breakdown. The parents wanted materials to be translated more efficiently, and they wanted translators present when they went for medical visits. They wanted screenings and testing to be done in the child's home language because they wanted to understand what was going on.

Celebrating holidays was a controversial topic in many sites. Those supporting celebrating holidays believed this helped the children appreciate and understand different cultures. Those opposed felt that the holiday celebrations could not, and did not, accurately represent the various cultures. Many of these programs tended to replace holidays with seasonal activities, such as replacing Christmas with a winter festival.

The major problems in the area of health were the lack of specialist providers and providers who could speak the language.

When parents did come into the classroom, most of their time was spent cleaning up and preparing materials because they felt teachers would then have more time with the children. When the parents did interact with the children, they tended to stay close to their own children and definitely within their own linguistic group.

Sometimes parents were asked to bring in culturally relevant items from their homes. For example, a family brought in a tea set from Lebanon and talked about how it was used. Others brought in traditional clothing and musical instruments and explained their relevance and read stories in their native language.

One significant finding is that across the country Head Start programs are approaching the challenge of serving children from diverse cultural and linguistic groups with great enthusiasm and in positive ways. Head Start administrators know the importance of addressing the entire family and not only the individual child, and they recognize the importance of tailoring their services so that they work with all ethnic, racial, and linguistic groups. As one father told me so eloquently, “Sending your child to Head Start is like sending him to your sister's; it is family.”

■ Descriptive Study of the Head Start Health Component

Chair: James Griffin

Discussant: Robin Brocato, Mireille Kanda

Presenters: James Griffin, Robert W. O'Brien, Michael J. Keane, Nicole C. Close, David C. Connell

James Griffin: When asking some questions, I found that people were not sure how the Health component was being implemented in Head Start. There was some information from the original objectives written in 1965, but since then there has been nothing available. We decided we needed a descriptive study of the Health component on a national sample of programs, which would provide an overview of how the Health component is being implemented across the country for children and families being served by Head Start. What we found was the richness of the Health component in Head Start.

Nicole Close: The purpose of the study was to determine how Head Start programs work to meet the requirements of medical health, dental health, nutrition, and mental health as outlined in the Head Start Performance Standards. This includes complete medical and dental examinations; follow-up referral or care; up-to-date immunizations; nutrition services—one hot meal, one snack per day; and mental health services—mental health training for staff and parents, a mental health coordinator, and outside mental health professionals.

The study's research questions include 1) what are the current procedures used by Head Start grantees to provide or obtain medical and dental health screenings and examinations, immunization records and immunizations, referrals, and treatments; 2) how are the health services documented; 3) what are the major health problems present within the four health domains for children enrolling in Head Start; 4) what are the major perceived problems and perceived risk factors present within the four health domains for children and families enrolling in Head Start; 5) how does the range and severity of health problems and service needs differ across Head Start programs and populations; 6) how promptly are the following provided across the four health domains—health screenings and examinations, immunization status and updates, referrals and treatments; 7) what is the range of treatments that are indicated and provided; 8) what follow-up mechanisms exist to document that referrals result in provision of recommended health services, including immunizations; 9) what community resources have Head Start programs utilized to meet the health needs of children and their families; 10) do community resources vary as a function of state Medicaid or public health guidelines; 11) what amount of Head Start program funds are used to pay for health services?

We were also going to look at barriers, whether it be transportation or limited availability or accessibility of health providers, and what families and programs face in attempting to access these community and state health resources. We looked at specific cultural factors within the four health domains that serve as barriers to health care utilization and at health education efforts directed to children and parents.

This was a two-phase descriptive study. Phase I began in October of 1993, with CDM and Abt Associates designing the study. The technical advisory panel developed the data-collection instruments and data-collection plans, chose the study sample and selection plan, and submitted the OMB package. In phase II, which began in March of 1994, a pilot study was conducted. There were data-collector training, data collection, quantitative and qualitative data analyses, a reconvening of the technical advisory panel, and report preparation.

We examined 1,200 child health records. Our sample included 40 Head Start agencies that were randomly selected. For each of these selected agencies, we randomly selected two centers.

We interviewed center staff and parents of 15 randomly selected four year olds. We conducted interviews with the center Director or Head Teacher, Health Coordinators, Mental Health Coordinators, Parent Involvement Coordinators, and Nutrition Coordinators, and a budget manager filled out a questionnaire. Research associates collected observations of the mealtimes. Site visits were made in teams. The team included the team leader, a research associate who was responsible for the overall site and did staff interviews, meal observations, and assisted the data collector; the data collector, who was responsible for interviewing parents and reviewing the child health records; and an on-site staffer, who handled the consent forms and coordination of the site as the central point of contact in recruiting parents.

The staff instruments included an interview about their background and the responsibilities of their role at the center; staffing policies; health histories, screenings and examinations; treatment services; and classroom and parent health education. The parent interview included family background; parent's perception of child health status; knowledge and use of Head Start health services; their child's medical, dental, and mental health information; and health education.

Michael J. Keane: I will report some of the findings on staffing and staff qualifications, procedures that the Head Start staff use in linking families with community health services, barriers to service delivery, and perceived health risks in the community.

Staff have been working in their current positions for from 9 to 15 years, with a mean of 6 years. Staff averaged between 35 and 40 paid hours per week, with the mean number of hours per week actually worked about five hours longer. We were interested in staff performing multiple roles. Our results reveal that about one third of the Directors and one half to three quarters of the other staff performed multiple roles. We also looked at the mean number of hours per week spent working in their primary position. There was quite a bit of variability here. At the high end were Health Coordinators who worked about 25 hours per week and Mental Health Coordinators who worked about 10 hours per week in their primary role. For those who were performing multiple roles, the average was approximately five to seven years in those roles.

We also compared the relationship between staff performing multiple roles and the size of their programs. The pattern that emerged was that staff who work in programs with enrollments of 500 or fewer children appear to be more likely to be performing multiple roles. For Health Coordinators, we found that staff in smaller programs appeared more likely to have multiple roles, while in the larger programs, the roles were more clearly delineated. These roles included Mental Health Coordinator (40%); Disabilities Coordinator (40%); and Nutrition Coordinator (36%). In terms of other component heads, the Mental Health Coordinators mentioned that their two major roles were Health Coordinator and Disabilities Coordinator. The Nutrition Coordinator most often mentioned Health Coordinator and Mental Health Coordinator roles. The Parent Involvement Coordinator often also acted as a Family Services Coordinator. The Director most often indicated that he/she performed the job of the teacher. Miscellaneous roles included bus driver or Deputy Area Director.

In terms of the education level for the staff in the Health component, approximately half of the respondents reported that they had a B.A. or greater. The lowest ranked are Health Coordinators. One third indicated that they had a B.A. degree or greater and also reported that they had nursing diplomas as well. Among the other staff, 35-40 % of Directors reported having a B.A. degree or greater, while 50% of Parent Involvement Coordinators and approximately two thirds of Mental Health and Nutrition Coordinators indicated that they had B.A. degrees. Of those with a B.A. or higher, approximately two thirds worked in programs with an average of 500

Research, Demonstration, and Evaluation Branch Symposia

or more children. This suggests that larger programs might be more successful in attracting more highly educated staff, perhaps because they have larger budgets and can pay higher salaries. Thus, it appears that the staff in programs with enrollments of under 500 are both more likely to be performing multiple roles and less likely to have B.A. degrees or higher. For those having certificates or licenses, 41% of Health Coordinators indicated they had a first aid certificate, and approximately 50% of the Directors indicated that they had a Child Development Associate certificate. When asked about training they had received during the past year, 81% of the Health Coordinators indicated they had training in first aid and safety, and just under 80% had training in CPR.

We asked both staff and parents a number of questions about payment sources for health services. The finding was that two thirds use Medicaid as a source of payment, which is similar to the data from the 1993 PIR, our basis of comparison. We then wanted to find out when the children were enrolled in Medicaid, how many were enrolled when they began Head Start, and if there was a relationship between the two. Two thirds (64%) were enrolled at or around birth, and about 21% became enrolled in Medicaid about the same time they were enrolled in Head Start. While it looks like Head Start may have some effect on enrollment in Medicaid, we cannot specifically say that. Those children not enrolled in Medicaid were either not eligible or had other insurance. Almost no parents responded that they were not enrolled in Medicaid because they did not know about the program, how it worked, or how to enroll.

Looking again at staff's roles and responsibilities, we found that 91% indicated that their jobs required involvement in establishing interagency collaborations. Health Coordinators and Mental Health Coordinators were involved in reviewing health providers, selecting providers, and negotiating payments. There was a great deal of variability on responses that Health component staff gave regarding community barriers to health care. Parent Involvement Coordinators tended to report barriers such as lack of child care, distance, and transportation. Health Coordinators and Mental Health Coordinators tended to focus on issues such as scheduling and provider-related items.

When asked about risk factors in the community, there was also a high degree of variability among the staff. Mental Health Coordinators very often reported issues such as substance abuse, physical and sexual abuse, and neglect. The Parent Involvement Coordinator named lack of immunization as a risk factor—an interesting finding. In discussing this we found that the Parent Involvement Coordinator becomes aware of this issue while assisting parents preparing their children to leave Head Start and enter kindergarten.

Question: Medicaid pays for 68% of Head Start children's medical costs, but how are health and mental health services provided by Head Start staff paid?

Michael J. Keane: Out of Head Start funds. We will talk about this when we discuss how Head Start health staff provide a broad range of health services, including arranging for them to go to a service provider. However, there is a distinction between medical care and health services. The question of payment has to be: Was the payment source to a medical care provider for the services provided by that provider, or was the service marshaling forces to make sure that children are taken to the dentist or to a physician's office?

Question: I wonder how compliance levels would vary on site as opposed to off-site delivery mechanisms? With Medicaid, there are state-by-state differences. What may occur in one

region or one state will not be valid in another. I wonder if there is a higher level of referral compliance by the patient with an in-house delivery system?

Michael J. Keane: One of the things that the Head Start staff try to do, and it did not appear on any of the data presented here, is to arrange for services to be provided on site to insure the involvement of the families or to make sure that the connection is made. We did find that the Health component staff spend a lot of time following up both with parents and providers on referrals that had been made to determine that the need had been met and that services had been provided, and, if they had not been provided, to try to remedy that situation.

Question: Some of the nurses must be providing direct medical services. Are they able to receive reimbursement from Medicaid?

Response: That depends on the state and their rules for Medicaid reimbursement. It is not necessarily related to the individual, but rather the facility. In my state I am not eligible to be a Medicaid provider even though I provide the same services as someone else with the same credentials, but who is with an eligible health care facility.

James Griffin: We seem to be losing the distinction between the health care provider and the broker of health care services. But, you are right, if somebody takes the child's height and weight, you could potentially say that is a health care service, but at the same time you are not going to get separate reimbursement for that. I think one of the things that is difficult about a descriptive study is that there are many variations. Some sites have registered nurses who actually provide direct services and may be reimbursed, while others strictly play the role of broker.

David C. Connell: I will be talking about areas where Head Start is involved in preventive services—the health education component and immunization. Health education for children and parents is a required activity under the Head Start Performance Standards. We asked the Health Coordinators several things about what classroom activities children engaged in that were health related. What we found was that there is a heavy emphasis on activities such as washing hands before meals, talking about good nutrition, talking about safety in the neighborhood or playground, supervised tooth brushing, good grooming habits, and safety at home. Some talked about feelings and friendships, tobacco and drugs, disabilities, and physical and dental examinations. The nutrition-related activities covered in the classroom were setting the table, cleaning up after meals, reading books about nutrition and taking field trips related to nutrition, such as visiting kitchens. Additional activities were cooking food, serving food, planting and growing food, and shopping for food.

We asked the parents what educational activities they knew the program provided. We did not ask them explicitly what activities they had taken part in, so we do not know what the actual participation rates may have been. Nevertheless, the areas most frequently mentioned included parenting and understanding child growth and development. The most important information we wanted was: What health issues do parents and children talk about following their entry into Head Start? We found a broad array of topics, and they matched what both the children are involved in the classroom and what the parents perceive to be the educational activities for them. Tooth brushing is at the top of the list, followed by washing hands before meals and other meal-oriented activities, safety at home, good grooming habits, feelings and friendships, good nutrition,

safety in the neighborhood and on the playground, use of tobacco and/or drugs, and physical fitness.

Next, we asked parents, in an open-ended question: What changes have they observed in their child in the areas of health, and did they make changes themselves? Here again, tooth brushing topped the list for children. For parents, nutrition and healthy food was the highest level item in which they changed. Most parents mentioned that the changes in their ideas about nutrition came from their children. The children brought home information about what they had eaten and what they had seen in the classroom. In addition, sanitary practices, feelings and friendship, physical fitness and safety at home, and safety in the neighborhood or playground were also mentioned as observed behavioral changes.

Regarding immunization, the Head Start Performance Standards require that children leaving Head Start at four years of age have their fifth DPT and fourth OPB in order to be eligible for school. Yet only five states require a fifth DPT shot and only 16 require a fourth OPB shot. The American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the CDC recommend that the fifth DPT and the fourth OPB shot be received between the ages of four and six, generally in conjunction with school attendance. However, these recommendations also say that one is not out of date if these shots are given by seven years of age. Looking at the PIR reporting criteria and the Head Start Performance Standards criteria, the Office of the Inspector General of HHS found that 88% of Head Start children were up to date with their immunizations. Our study, which replicated the OIG study, found that 82% of the children were up to date at 4-3, but only 29% were up to date at 5-4. That drop-off is almost entirely associated with DPT and OPB. We had the advantage of having parent interviews and actual immunization records. We found that the parents' records showed additional DPT and OPB shots that the Head Start records did not have. In the case of DPT, roughly 14% and in the case of OPB, about 10% of the actual records (brought in by about 45% of the parents) showed additional shots. There may be some confusion around standards, which is likely to continue until everybody is on the same page (states and federal government requirements and recommendations), but at the same time there is currently a reasonable approximation of full immunization in the Head Start population.

Robert W. O'Brien: While the health of the nation's children has improved in recent decades, poverty continues to have a pervasive effect on the health of children, particularly from low-income families. What we set out to do was to look at health examinations and screenings, the health status of the children in Head Start, and treatment. It is clear in the Performance Standards that trained nonprofessionals can do a number of the screening activities. For example, they can take medical and dental health histories, conduct growth assessments and vision, hearing, and speech screenings. It is also clear that examinations are to be carried out by trained professionals.

I am going to talk about results across the four health domains: mental health, medical, dental, and nutrition. In looking at the results, we collected data from the parents and Head Start health records. We wanted data from multiple sources, but were unable to obtain data from the children's primary health care providers due to lack of available resources.

Directors listed childhood illnesses, lice, dental/oral health problems, flu and colds, asthma, and lack of immunizations as the major perceived health problems at their centers. Health Coordinators listed dental and oral health problems, asthma, blood disorders, lice, childhood illnesses, malnutrition, hearing problems, and immunizations. There is some overlap between the two groups, but we were struck by the differences between them. The Health Coordinators tended

to have a more administrative role, and the problems they list indicated that they were going to have to do some work to find services. Directors, on the other hand, seemed to touch on problems that directly affect what happens in the classroom. The Mental Health Coordinators primarily reported behavior disorders, with aggressive behavior the most frequently reported.

ACYF was interested in the role of Head Start in facilitating children getting physical and dental examinations required under the Performance Standards. For many children, we had a date of physical examination, and just by estimating July of 1993 as a rough approximation of a start date, we found that most of the children were getting physical examinations right around the time of starting the Head Start program year.

The parent interviews and the children's health records were examined, and we developed a coding system to pick up whatever medical condition might be there. The results indicated a higher prevalence of conditions listed on the parent reports than on the children's health records. There is some evidence that not everything that is going on with these children is getting into the Head Start health files. Conditions such as blood disorders, speech and language problems, dental/oral health problems, and hernia were rarely picked up prior to Head Start. We believe that may have something to do with the requirement of the Head Start physical exam. About one third of the parents reported no health problems for their children. A much higher percentage, close to 60% of the health records, had no listing of any health problem for the children. Based on parent reports, 40% of the children had one health problem and 30% had two or more health problems. Based on the record reviews, it was about 20%.

We listed types of reported serious injuries separately from health conditions. The major ones were abrasions, cuts and stitches, and orthopedic injuries.

Question: Were these injuries before Head Start or while they were in the program?

Mr. O'Brien: It could have been either because we collected the data at the end of the year. We do not know whether the injuries occurred while the child was at Head Start or not. One of the things we did find was that there were very little data in the Head Start health files about follow-up and treatment. We tried to find out if treatment has been completed, if it is ongoing, or if the parents did not seek treatment.

We found that most children had had dental exams within the past year. Thirty to forty percent of the children had no problems, while many needed cleaning, fluoride treatments, restoration, extraction, and fillings. Where health records were missing information, we double-checked with the parent records and found that over 90% reported that the child had had a physical exam or a dental exam within the past year, which looks very much like the PIR reports. A number of centers did not even use the Head Start health record for their data collection on dental information, and might have had the carbon copy of the report from the dentist's office. In a number of cases we were unable to find any report about a dental examination and no actual information on what occurred in terms of findings and treatment. Reports by parents for conditions noted during a dental examination included a majority of the children requiring fillings, caps and crowns, or teeth pulled. Preventive care was prescribed as well. From parents we found that most had completed treatment, many were still ongoing, and nobody reported that treatments were not being sought where they were needed.

When staff and parents reported nutrition problems, they were within the context of medical health problems. Eighty-seven percent of the Nutrition Coordinators we interviewed said that

Research, Demonstration, and Evaluation Branch Symposia

children in the program received nutrition screenings when problems were determined. We found a list of nutrition referrals in the Head Start child records.

Mental health was another area where we had problems collecting data. In the mental health domain, children may receive group screenings, individual screenings, and they may be referred for a full assessment. We are not convinced that parents really knew about group screenings. If there was a mental health consultant, classrooms might be observed or evaluated and then individual children picked for further individual screening. In these cases the parents would be notified. Very few parents in our interviews indicated that they had been asked for permission to conduct a behavioral or developmental assessment of their child. Terminology is another problem. Some people clearly think of mental health as focusing on mental illness. Head Start, on the other hand, looks at mental health in a much broader sense—in terms of normal development and in the development of social competence. This distinction must be made clear when we talk about the Mental Health Component. Were we to do this study again, we would do this aspect of it very differently. There is probably a need for a separate study of mental health because it really is addressed differently than the other health domains. A recent study indicated that a good deal of information that is collected in mental health screenings does not get into the child's record. Often staff address it on the side and do not want to put the information in the record that will follow a child into elementary school and may cause a problem later on. This means that we end up with incomplete data. Because of unclear terminology, such as "developmental assessment," "behavioral/emotional problems," and so forth, some of the mental health information may have ended up in education assessments or in a child's educational file, which we did not have access to.

Comment: There seems to be a problem with standardization of forms that are used.

James Griffin: There is one hopeful sign for the future in this regard. We now have the Head Start Family Information System. This is an immunization screen that is part of a computerized system that is being developed.

Mireille Kanda: We use certain markers, such as immunization, that are defined by the Performance Standards. With immunizations comes a discussion of other issues, such as prevention, guidance, and so forth. Another aspect of it is the diversity of the effort, depending on the program. How, if one really wants to use the concept of franchise, can this happen in Head Start? This is not the hamburger, i.e., where wherever you go, there is the same hamburger that looks the same. Each one of these products is unique. If we expect that we are going to have the same product everywhere, we are setting ourselves up for frustration in terms of the realities of the communities in which those children and families live. That brings us to the issue of flexibility, especially in terms of policy. We have to look at systems that are responsive to the needs of the community and that involve a certain amount of flexibility. The data that we have looked at to date help us to identify issues that need to be further examined. Certainly a good example of that is the issue of documentation in its various forms, starting from the records and the exchange of information. Maybe a parent does not always tell the Health Coordinator or the teacher about what is happening with the child necessarily at the time when it is happening. There is also anecdotal information from teachers and Health Coordinators about the burden on their time.

BEST COPY AVAILABLE

219

Robin Brocato: When I came to the Bureau from HCFA, Office of Research and Demonstrations, I asked, "Where is the data?" And there was none. So I think this study is exciting and it has been a long time coming. At the beginning of the study some good things were incorporated into the method that was used. First, having an on-site staffer, often the Parent Involvement Coordinator, helped in encouraging parents to participate. Second, we talked to people who worked in the different components. This helped us to look at health from a broad perspective. The value of this approach was evident when we looked at the barriers that were reported by staff and how different staff had different perceptions of the barriers. The role of the parents proved to be very important when we looked at immunizations. Often the parents had information that did not appear on the child health records, and they were able to supply us with that information.

One finding that was exciting was behavior changes as a result of the health education in Head Start reported by parents. They reported changes not only in their children's behavior, but also in their own habits, especially in the area of nutrition.

Interestingly, the revised Performance Standards are going to require, for the first time, that the person managing the Health Component have education and experience in the area of health. Our data showed that at least two thirds of the staff in the Health Component had nursing training. There was concern that staff working in the Health Component may not have had the specific training necessary. This study reassured us that many Health Component staff do have those qualifications.

■ Strategies for Working with Children and Families from Substance-Exposed Environments: Research and Its Implications for Head Start Practitioners and Policymakers

Chair: Mary McEvoy

Discussants: Judith E. Jones, Dwayne A. Crompton, Sharon Shapiro

Presenters: Scott R. McConnell, Judith C. Carta, John M. Love

Over the past two decades, researchers from a variety of disciplines have explored the effects of prenatal exposure to licit and illicit drugs on the neurological and behavioral development of children. Recently, research in this area has begun to consider the influence of family, school, and community contexts, in addition to drug exposure, in the development of these children. An overview of a large multisite longitudinal study examining both risk and protective factors affecting the development of children with and without polydrug exposure between birth and five years was presented. Barriers and facilitators to creating effective Head Start partnerships for strengthening families and building neighborhoods to reduce children's vulnerability to substance abuse were also discussed.

Longitudinal Study Examining the Role of Caregiving Context in the Development of Children with and without Prenatal Exposure to Illicit Drugs and Alcohol

Mary McEvoy, Scott R. McConnell, Judith Carta

Paper summary not available

Head Start/Community Collaborations for Preventing Substance Abuse: Lessons from the Evaluation of the Free To Grow Initiative John M. Love, Irma Perez-Johnson

In 1994, the Robert Wood Johnson Foundation funded six Head Start grantees to design and develop "model substance-abuse prevention projects that will strengthen both the families and neighborhoods of economically disadvantaged preschool children." The initiative, named "Free to Grow," targets the families of Head Start children, other significant adults in the children's lives, and the children's neighborhoods to create change that will free young children to grow and flourish while protecting them from the risks of substance abuse and its associated problems.

In the first 18 months of project planning and development, Free to Grow grantees encountered some difficulties in recruiting families, but three types of objectives and associated strategies emerged from their work. All projects have developed working partnerships. Partners play different roles in the different sites, participate in project activities to varying degrees, and exercise varying degrees of leadership. The models generally involve multiple strategies, address a range of risk factors, try to enhance protective factors, and reflect sensitivity to communities' cultural and racial/ethnic diversity.

Head Start experience has proven an asset for the projects in a number of areas. In particular, Head Start programs are intergenerational programs that recognize the importance of a family-oriented focus in the design and implementation of programs aimed at supporting the health and development of children. Head Start programs have also traditionally supported active parental involvement in their children's lives and, consequently, encouraged parental involvement in program activities. These features enhance the likelihood of success of Free to Grow projects at involving families in project activities and addressing family-related risk factors associated with children's vulnerability to substance abuse. In addition, most programs already have well

established service provisions or referral networks that allow them to link families to a wide range of direct and supportive services. The prevalence of these pre-existing relationships with local providers and/or agency representatives not only facilitates service delivery for at-risk families, but also facilitates the formation of partnerships and collaborations for community-focused work. Head Start's emphasis on parent participation in program governance programs provides a sound foundation for the establishment of community-focused forums and mechanisms for local action and resident participation. Finally, Head Start programs are generally viewed as constructive institutions in the communities they serve, which gives the Free to Grow initiative credibility and facilitates the recruitment of local residents, agency representatives, and other important players for neighborhood organizing work.

■ Preventing Community Violence: What Works?

Chair/Discussant: J. Lawrence Aber

Presenters: Penelope Trickett, Felton Earls, Laurie Miller, John Lochman

J. Lawrence Aber: In the United States, while crime as a whole may be declining, violent crime among youth ages 15 to 24 is mostly on the rise. Work by criminologists like Al Blumstein at Carnegie Mellon University and others suggest that there has been a discontinuity in crimes such as youth homicide in the last decade, where there has been a significant increase. This growth may continue until it peaks around the year 2010. As a result, we are experiencing some changes in our communities, and this is one small example.

Youth and community violence are not evenly distributed among America's low-income communities. Some low-income communities are high in what some people refer to as social capital—the density of friendship networks and the richness of relationships that permit organization in the face of poverty. Other communities are disorganized and isolated. Increasingly, researchers, practitioners, and people interested in policy must become aware of how variations in community contexts affect Head Start quality, Head Start effects, and other related issues. It is not rhetorical to make comparisons like the one that Jim Garbarino makes. Jim has done analyses that look at the rates of exposure to serious violence in some American communities and compares them to children's exposure to violence in war areas like Mozambique and parts of the Middle East. He finds equivalent exposure rates in some inner-city, American neighborhoods for children in areas of war.

In this symposium we begin to explore the possible relationships between community violence and Head Start initiatives. It is probably too optimistic to say "Community Violence: What Works?" I suggest that we rephrase the symposium title to "What Could Work?" The presenters have accepted the task to describe either what we know or what we will know about the effects of community violence on children, and/or what we know about prevention programs designed to reduce the risk for violence. We will then think about the implications of their work for Head Start. The goal is to begin to develop a research and action agenda for Head Start on coping with and preventing violence.

Penelope Trickett: I have been asked to talk about what we know from research about the impact of neighborhood or community violence on children's development and to think in terms of what the implications of that knowledge and/or lack of knowledge is for intervention or prevention efforts.

There is and has been considerable concern about the developmental impact of neighborhood violence on young children. However, there is almost no empirical research with children as young as Head Start children. Currently, I know of two studies. The first study is being done with a Head Start population by Joanne Farver, who is at USC with me. It is a small study with a sample of 60 Head Start children and their parents and is located in south-central Los Angeles. Most of these children are Latino. She is just finishing her data collection this week. Her methodology involves interviewing both the mothers and children and getting teacher reports on child behavior, as well as conducting observations within the classroom.

The second study is being conducted by Karen Saywitz, who is at Harbor UCLA Medical Center, which is also in inner-city Los Angeles. She has a large sample of over 250 children ranging in age from 4 to 16. These are all children who come in to a public psychiatric clinic for children and adolescents. These children are about equally divided between Caucasians, African

Americans, and Latinos. Her focus is on finding out the prevalence of exposure to neighborhood violence and how coincident it is with history of child abuse. She wants to see to what degree the nature of the symptoms or behavior problems of these children relates to their degree of exposure to neighborhood violence and/or child abuse. She has some preliminary results that indicate that there is an association in her sample dependent on the degree of their problems and of their exposure. So far she has not done any analyses that specifically look at developmental differences or that would give us some indication of whether these findings hold true across this age range or are different for younger children.

There are a number of studies that have used samples of school-age children, often older elementary, and looked at the relationship between degree of exposure and different problems. There are also studies from other related areas, such as research on children growing up in other cultures where war is going on. Other related research topics include children who have been exposed to a one-time traumatic event such as a sniper attack; children who have experienced disasters of one sort or another; or children who have experienced non-manmade violence like earthquakes, hurricanes, tornadoes. There is also relevance from studies of children who experience physical abuse and/or witness domestic violence in their home.

All of these studies are not exactly what we wished we had in terms of understanding neighborhood violence on young children. Many of the studies on child abuse do not focus on developmental differences. There are also other differences, such as whether the children are exposed to violence or are experiencing it themselves, whether it is violence that occurs within the family versus outside the family, or whether it is an acute single occurrence versus chronic. All of those factors make a difference, as do cultural differences in some of the studies of European war-torn nations. Nonetheless, they can teach us something.

Most of the school-age neighborhood violence studies have focused on the degree of distress or anxiety exhibited by children as a function of the degree of exposure. Nearly all studies have found this to be true: the more violence you are exposed to, the greater your anxiety or distress. Different studies have used different assessments. Many use self-reports by the child; some use parent reports; some look at symptoms of Post-Traumatic Stress Disorder (PTSD).

Research on child abuse, both physical and emotional, and domestic violence has found not only aggression and externalizing problems, but depression and other internalizing problems. In both of those areas, people started with the notion that exposure to violence produces violence. They were expecting to find aggression problems and surprised to find depression as well. The implications for neighborhood violence impact are probably similar. What this suggests is not particularly surprising, but it is still important to take into account that children exposed to different sorts of violence show a number of different kinds of effects: aggression and other externalizing problems, as well as depression, anxiety, acute distress, low school competence, and in some cases, low social competence. This is particularly important as we think about developing interventions, particularly to prevent neighborhood violence. We do not want to think of these young children as only potential perpetrators of violence 10 years down the road, but also as being impacted in a number of different ways.

One other finding from the school-age neighborhood violence research is the potential mediating role of the family or the parent. For example, Hill and Medare found that family as well as peer and teacher support mediated different areas of maladaptation in their sample. Richters found the following in several studies: first, the mother's education level mediated the relationship between amount of exposure to violence and distress levels; and second, the combination of exposure to violence and family instability, which he was not measuring in terms of vio-

Community Violence and Substance Abuse

lence but other aspects of instability, were especially predictive of both school and behavior problems. The combination of these two were more likely to lead to problems than one or the other exposure. Osofsky found a relationship between family violence and neighborhood violence. In her sample, the children who were exposed to the greatest degree of violence in the neighborhood were also most likely to come from families in which there was violence, either spousal violence or child abuse.

I do not think that these findings are especially surprising, though I do think they are critically important to keep in mind as preventive interventions are designed. It is important to consider a couple of things. One is how living in these same violent neighborhoods affects the parents and thereby affects their parenting. There have been some suggestions that in some cases it makes the parents depressed and withdrawn, and they become less involved with their children and provide less structure for them. In other cases, it makes them especially restrictive in ways concerning their children's safety, which may not be good for their children's development of independence and autonomy. There is also a suggestion in this research that some parents underestimate the amount of violence to which their children are exposed. As those studies are school age, I do not know whether this would be as true with younger children or whether they adopt a sort of denial mechanism in order to cope with this situation. However, that would have implications for the parenting of the child.

Felton Earls: I am going to talk about neighborhoods. In medical school and residency and all the training that psychiatrists go through, I never learned anything about neighborhoods. I never thought one could put a neighborhood on a couch or give a neighborhood a drug. So it has been in the context of evolving research that I have been forced as a public health doctor to move from the clinic, the couch, and the drug to neighborhoods. What I want to talk about today is what I am learning about studying neighborhoods.

First, we as sociologists have studied neighborhoods for a long time, for well over 100 years. The concentration of this effort has been on studying the link between poverty and delinquency. Basically, it shows that there are three factors that represent the structure of neighborhoods that relate closely to differential rates of delinquency. The first factor is poverty itself. Another one more important than poverty is residential instability: the number of times people move. The third is ethnic heterogeneity. However, these three factors describe what I will call structural properties of neighborhoods. The factors did not tell you how it was to live there or grow up there; they told you something about indicators of what kinds of resources and membership existed in these units.

Modern sociology has begun to revise this old story, derived from the work of people like Clifford Shaw, McKay, and the University of Chicago school, by looking at new forms of poverty. For example, the kinds of poverty that now exist in cities are described as extreme and concentrated. That kind of poverty did not exist, or at least was not well described in studies that were started before the 1960s, and possibly even the 1970s.

Another issue is that rather than studying poverty, the dynamic is changing to study income inequality. To some extent this derives from people who have studied famines, for example, which is an extreme kind of poverty, and have discovered that famines never occur, or rarely occur, in the absence of foods. The studies show that famines result from a distribution of a resource—in this case, food. The issue in poverty is the shift to a distributional question, and looking at what the dynamics are in a society that allow some people to live below a poverty line

and other people to have extreme wealth. Almost every country in the world now is experiencing growing income inequality.

The third important thing is that the economy has been restructured. Rather than an agricultural or industrially based society, we now have a technologically structured economy, which requires different kinds of workers, and probably fewer workers. Therefore, joblessness becomes another important aspect of studying communities.

These characteristics, however, are still getting at structural properties; they are not moving the sociology to a more functional level where you can experience what it is to grow up. Ethnographers have done this on small population bases, but for the most part we have not studied many neighborhoods simultaneously—asking a question, thinking about distribution of resources, how it is to grow up in a variety of types of neighborhoods in the same area, the same country, the same city, and so forth.

The work that my colleagues and I are doing has focused on the City of Chicago because Chicago offers a variety of neighborhoods stratified by race, ethnicity, and social class. In one place we can study African Americans, Latinos, both from Mexico and Puerto Rico, and White ethnic groups. Additionally, within each of those major ethnic streams there are also income gradients. With that in mind, I would like to show some visuals of Chicago and the kind of design that we are creating to put the neighborhood on the couch.

This map shows a pattern of what sociologist demographers called hyper-segregation. They claimed that Chicago was the most segregated city in the United States, maybe in the world. We were interested in taking a map of the city and stratifying it by social class and ethnicity. We had to create our own definition of neighborhoods, but basically we took census tracts. Census tracts do bear some similarity, at least they did 80 years ago when they were defined to neighborhood boundaries. As highway systems have developed and housing has been created, these census tracts do not have the perceived neighborhood quality that they did sometime ago. Despite that, our definition of neighborhood is largely geographically driven. That is an important reservation to have about this. We came up with 343 neighborhoods. There are about 860 census tracts in Chicago, so these neighborhoods are about two census tracts large. This means that there are about 8,000 people who live in these units. There are 125 of these units that are predominantly African American. Seventy-five percent are more African American, and some of them are 95% to 98% African American. Seventy-four percent are predominantly White; 21% are predominantly Latino.

It was interesting to find many neighborhoods that were relatively mixed. So the idea of hyper-segregation was not quite true. There are about 50 neighborhoods that would be characterized as multiethnic. It is important, however, to recognize where the big numbers are. First, there are many very poor, predominantly African-American neighborhoods. That is the biggest number of any cell size on the map: 77. It is also important to recognize that there are no predominantly poor White neighborhoods. There are no predominantly Latino wealthy neighborhoods (wealth, in this case, being a mean income of \$50,000 or more).

Already this begins to drive home a certain kind of ecological reality that is reflected in the notions of extreme and concentrated. We have launched a series of survey approaches in each of those 343 neighborhoods. The first is to choose in each of 343 cells a random selection of household residents and talk to them about their perception of the neighborhood. We asked them how they defined their neighborhood. By how many blocks? Could you draw it on a map? Some people say my neighborhood is this side of the block and that is it. Other people say my neighbor-

Community Violence and Substance Abuse

hood is 20 square blocks called Woodlawn, for example. Already you have a perceived variation in what you geographically have called neighborhood.

We then go on to do what we call systematic social observation. In this case we equipped a van with two video cameras that were fixed at opposite sides of the block. We call these block faces. Then the van drove at a slow speed—three to five miles an hour—through the block recording what we saw. We were particularly interested in social characteristics, not just physical ones, so we did record gang graffiti, boarded-up houses, and so forth. We were, however, particularly interested in children. We made counts of the number of children we saw spontaneously who were supervised or unsupervised. The number of unsupervised children becomes a marker of social processes within the neighborhood.

Third, we selected groups of people who do not necessarily live in the neighborhood, but who work in the neighborhood, such as school teachers, businessmen, church leaders, and politicians. We call them key informants. We interviewed them about how they perceived the neighborhood, and about the capacity of these professional people, for the most part, to work with neighborhood residents to mobilize in the interest of children or in the interest of other notions of well-being. Finally, we accumulated a great number of administrative records. One of the reasons we worked in Chicago is because Chicago keeps good records, even down to garbage collection in neighborhoods.

We have gone beyond the markers that I told you about before—ethnic heterogeneity, poverty, and residential instability—to measure the functional properties of neighborhoods in terms of what it is like to grow up there. Pay particular attention to the theoretical constructs that we call informal social control, formal social control, and social cohesion. Those are questions that have to deal with: Do you know your neighbors? Do you know children who live in this neighborhood? If you were in trouble or needed an egg or a cup of sugar or five dollars, are there people that you can depend on? That is informal. Formal social control are organizations such as choral societies, recreational activities, and PTA associations. There we are interested in how many people belong or how many people vote in local elections. There are neighborhoods in Chicago where more people vote in local elections than vote in national elections, for example. Social cohesion is about values. This is about the degree to which there is a consensus in the neighborhood about values of keeping up one's property or taking care of children.

While our study is ongoing, I want to illustrate how we are going to use these data about communities to describe something about children growing up. This model looks at three levels of evidence or data. One is at the community level; the second is at the family level; and the third is at the individual level. I do not have time to go into the kind of data we are collecting about families and individuals. However, this model begins to give you some idea of how we want to make sense out of the important role that communities play in outcomes like delinquency, substance abuse, teenage pregnancy, or school grades. We are looking at community properties like informal social control and how that relates to family management.

This project and many other projects are moving sociology and its concern about the structure of neighborhoods into a more functional public health approach where we are asking, "What is the quality of life in these neighborhoods? Can we study properties about neighborhoods that allow us to form interventions at the neighborhood level that change the way families manage children and children grow up?" If we have time for a discussion, I would like to speculate on some of the things that we are finding about these functional properties in neighborhoods that might lead to ways of approaching neighborhoods. I do not want to call it intervention anymore

than I would call a playground an intervention, but call it ways of influencing neighborhood development and neighborhood activation to improve the quality of life for children at all ages.

J. Lawrence Aber: I want to mention one thing before turning to Laurie and John. Keep in mind the last model that Tony described. In a certain way, that model summarizes a lot of what we know about the effects of family processes on children. There is increasing research that suggests that participation in Head Start-like programs affects self-control in the preschool years and the probability for delinquency later. What is important about Tony's presentation is beginning to think about a theoretical model that places the family and the individual in a community context, and its implication for Head Start policy and practice.

Laurie Miller: I am going to talk about a pilot project on the prevention of antisocial behavior. This is a study that we have been working on over the last three years, and we are just completing the first phase. The goal of the program is to prevent antisocial behavior. There are several reasons that we are working in the preschool period. One is that longitudinal studies have shown us that for many children who grow up to be antisocial teenagers and adults, this pattern of behavior starts as early as the preschool period and possibly before then. We also know that children who are aggressive, noncompliant, or oppositional start to suffer the secondary consequences of this kind of behavior by the time they enter school, as they are easily rejected by peers and teachers. We know from the developmental literature and from treatment studies that parenting practices are important, especially in this early period. Therefore, we are talking about things like being consistent, not using physical punishment, and so forth.

We have gained a lot of important information from therapeutic interventions. One piece is that if we try to treat children who already display severe antisocial behavior, especially if that behavior started very early on, we do not have great success. There are a lot of reviews of promising interventions, but we do not have any single intervention strategy that has been shown to change the developmental course for children already presenting severe antisocial behavior.

What we do know from these intervention studies is: 1) if you change parenting practices, you can change behavior problems in children; 2) child-focused approaches do not seem to work, in that if you only work with the children individually and ignore the family, you will not have positive results; and 3) probably the best approach comes from multisystemic approaches in which the focus is on the children, the family, and the community.

Therefore, we focus on parenting practices. This is not to ignore other factors. It suggests that parenting practices can mediate many of these other factors, although there are still some independent effects. I will try to talk about some of those things and how we conceptualize our approach.

Basically, this is our simple view of what we are aiming to do. If we change parenting practices in children at risk early on, and we help children develop social skills that insure socially competent behavior and prevent the development of problems, we hope to prevent the development of antisocial behavior over time. We focused on children who we considered at great risk for the development of antisocial behavior. These are children who are two-and-a-half to four-and-a-half years old who have older siblings with histories of delinquent behavior.

In the pilot study we recruited primarily from the court system. We screened court records of juveniles convicted in Manhattan and the Bronx and approached all the families with children in this age range. We also tried to recruit from our clinic at Columbia but with little success. It seems that, at least in our community, children that have severe antisocial behavior do not end up

Community Violence and Substance Abuse

in our clinic, but end up, unfortunately, in the court system. We ended up working with 30 families, primarily mothers, although we have a couple grandmothers. They are primarily African American and Latino. Most of the mothers are single, living alone, or living without a partner. The study design was a randomized control trial, though it is small. The intervention is a year long; the follow-up at this point is a year. We are hoping to replicate this with a larger sample and follow these children into school age.

The children that we are working with are three years of age. They are primarily males because we started out working in the first cohort with only boys, but we are no longer doing that. The I.Q.s are below average. What is important is that their CBCL scores are in the normal range, so we are selecting children who we think are at high risk, but who are not presenting significant behavior problems at this time. That is what we were aiming for.

There are four parts of this relatively intensive program. We have a parenting group, a children's play group, what we call parent/child interaction training, and home visits. The majority of the work is done in the clinic, although we have an eye towards what is going on at home. Everything we do is to help the parents interact with their children differently in their home settings.

The parent group is done at the same time as the children's group. We are attempting to teach parents the basic elements of a behavioral parent training program, including helping parents to play with their children. We teach these parents other effective parenting skills such as praising and rewarding socially competent behavior, how to set limits, ignore misbehavior, use time-outs, and use preventive approaches. There are other important things that I will not have time to talk about, but these are the goals of what we want to teach parents.

There is a tremendous amount of work that goes on before parents can learn these things. We are trying to describe what this work entails. As you know, many of the parents are depressed and highly stressed. They all have older children who have been in and out of the criminal justice system. For many of them the children's fathers have been in and out of jail. The majority of these families are poor and have limited resources. These are the kinds of things that we are focusing on in order to help parents to learn these skills. At the same time, the children's group focuses on teaching children social skills and peer interactions—although our main focus is on the parents and helping the parents to learn new behaviors to try at home. Parent/child interaction training is a setting in which the parents and children work together so that we can help the parents implement these skills.

The home visits are essential so that we can help parents generalize the skills at home and so that we can see important family members who do not come to the clinic, including grandfathers, grandmothers, and fathers, as well as neighbors who are involved in the children's lives. The visits allow us to see what the homes are like and to have an understanding of the community.

One of the most important outcomes that we were looking for in the development of this program would be attrition rates, attendance rates, and parent satisfaction. We have about a 10% attrition rate from this study, which I think is quite impressive, given the kinds of stressors facing parents. We have an attendance rate of 70% at our groups, which meet twice a week for nine months. In satisfaction questionnaires, all the parents are telling us that they are getting something important out of the program. That in and of itself is a positive outcome.

Our measures of parent functioning and child functioning are blind observations of parents and children interacting together. These are global ratings of videotaped interactions. The intervention group and the control group are not completely equivalent, unfortunately, and that is due to the small sample. However, the pattern is that by the end of the intervention, the intervention

parents are becoming more responsive, affectionate, and attentive to their children. This is maintained to some degree at a six-month follow-up, whereas the control group seems to be going downhill, even at this early age of the children.

We have the same pattern with the intervention children. Basically, the treated children are becoming more socially competent over time versus the controls. These are parent reports of children's disruptive behavior on the CBCL. The treated children are less disruptive over time, and the control group are becoming more disruptive. In fact, even though it is a smaller number of children in the follow-up, those children have a mean in the clinical range. This is the pattern that we would hope to find, and we are hoping to be funded to do this on a large-scale basis with 100 children next year.

John Lochman: FAST TRACK is a comprehensive, long-lasting intervention that starts in early elementary school and continues throughout the elementary school years. It has two major prongs: one is a universal prevention focus and the other is an indicated or targeted prevention focus. I am going to describe the intervention model and give an overview of our early findings.

FAST TRACK, at least at the indicated prevention, or targeted prevention level, operates on an early starter developmental pathway model, in which we assumed that there are children who are going to eventually have these negative outcomes. There are early markers on their developmental pathways that can be identified in the preschool and early school-age period. These early signs and the signs that continue to escalate over time involve a combination of overt and covert externalizing problem behaviors. The research literature suggests there is a high degree of continuity or stability in these behaviors over time. It is apparent that once children begin to be aggressive, they have a high rate of remaining aggressive and a poor prognosis. They have high rates of criminal offending, conduct disorder, and substance use as they move into adolescence.

Our program is designed to identify children at the indicated prevention level at an early age and offer an intensive program to them. Our high-risk sample is identified across four different sites around the country: Seattle, Washington; Nashville, TN; Durham, NC; and a rural area around Penn State. We have three cohorts of children and just under 900 high-risk children that we have identified. They are identified on a multiple screening system that consists of conduct problems that are apparent in kindergarten, according to kindergarten teacher and parent ratings.

Overall, across all sites, 47% of our sample is Caucasian, 52% African American, 3% other. Not surprisingly for our targeted groups, we have a higher rate of boys identified than girls, with about a two-to-one rate of boys being identified with these early markers. Children in this high-risk sample are randomly assigned by school to intervention or control. We also have a normative comparison group that we follow. It is apparent that the children in the high-risk sample come from contexts that have multiple problems. The family context, as we first look at them in kindergarten, involves high rates of family conflict and violence.

We have parents who are using substances at high rates. This is an ongoing clinical problem in terms of trying to engage them in parent training. Parents also have a variety of personal adjustment problems of their own, such as depression and other types of antisocial behavior. Families tend to be insular. These are families who have relatively few social support systems around them, and they are economically disadvantaged. According to parent interviews, they are coming from high-risk and unsafe neighborhoods.

The time line for FAST TRACK is relatively long. We start screening in kindergarten and continue assessment throughout high school. The intervention is provided in a somewhat pulsed

Community Violence and Substance Abuse

way. We have fairly intense intervention periods in first and second grades at the child's entry to elementary school and, again, in fifth and sixth grades at the child's transition into middle school. It is another time in which parents and children seem to be more open to intervention. Then in third and fourth grade, we continue intervention, but at a somewhat reduced rate. In grades one and two, there are seven program components that we developed. One of those involves home visiting to the family. In the school we provide paths such as tutoring and peer pairing. The enrichment program can be offered in schools or in community centers, and includes parent groups and friendship groups or social skills groups for the children that are run at the same time. That is followed by a parent/child sharing time for them.

PATHS is the universal prevention part of the program and consists of a set curriculum that is offered to teachers to use in their classrooms with all of their children. The focus of PATHS is developing children's emotional understanding through self-control, social problem-solving skills, and peer relations. You will notice that for the friendship group and peer pairing, which are components offered to these high-risk children, many of those targets are the same.

The high-risk children are receiving intervention on goals for multiple intervention components, and we feel from our clinical perspective that this is a key part of FAST TRACK. We have high-risk children who are working in their friendship groups on issues relating to problem-solving, for example. They also do that in peer pairing and hear it in the whole classroom and in the PATHS part of the program.

We provide reading tutoring to children. The primary reason is that there are clear associations between children's externalizing behavior problems and their increasing academic problems over time. In the parent group, we focus heavily in the first six or seven sessions of our contact with parents in first grade on family/school relationships. We are interested in promoting early positive parent engagement with the school setting. There is a focus on parent self-control, so we work with parents on managing stress and anger. We have found those sessions to be some of the best received. In the parent group, we cover typical parent training topics like the parent's expectations for the child and the parenting skills like the ones that Laurie has talked about. Our parent/child sharing time is also felt to be an important part of the program. It is a time for parents and children to do things together in a positive way, promoting positive parent involvement.

In the home visiting component, the key issue has been to promote ways in which we can empower parents to problem-solve. From an implementation standpoint, the issue is how to avoid getting trapped into being the provider to the parent and instead to facilitate parents. It is a continual effort to work on that.

We have a variety of measurement methods, many of which are administered to parents and children every summer in structured interviews. We also have independent observations of parent/child interaction and of classroom and playground behavior. We use sociometric interviews throughout these early school years. We will be looking at our archival records over time.

Looking at the end of the first grade across all three of our cohorts, we find that at the universal prevention level where we offered PATHS to everybody in the classroom, according to teacher ratings, children in these intervention classes are less disruptive. According to those peer sociometric ratings, all of the children in the classroom are better accepted by their peers. We get that effect even if we remove the target children from that part of the sample. The effects are being carried by a systemic change in the population within the classroom, which is a key issue. There is some indication of effect on the environment around our target children and within the classroom. There are significant effects on word-attack skills on the part of intervention children related to tutoring. On our measures of children's social and coping skills, we find significant

effects on almost every measure that we administered to the children. We find that they become more accurate in their emotion recognition and more competent in social problem-solving. This is a set of skills that have been impacted by multiple parts of the intervention by PATHS, friendship skills, and peer pairing. Across the board, it looks like children pick that up.

In terms of parenting behaviors, at the end of the first grade the picture is more mixed. We find that when parents self-report and they are faced with problem situations, we do not get significant intervention effects. However, if we look at the observations that are made of the live parent/child interactions, the intervention parents have greater parent/child warmth and involvement and they have more appropriate discipline. When we ask parents what they would do if they were faced with some hypothetical vignette situations that involve child problems, they would report using less physical punishment and more withdrawal of privilege. There is some indication of beginning change for parents, though it is just beginning. Additionally, we find that the teachers are rating the parents as becoming more involved with schools and placing greater value on education. Finally, in terms of children's problem behavior, we also find that there are some indications of some mixed effects at this point at the end of the first grade year. We do not get differences on the child behavior checklist or on the aggression nominations in sociometric measures.

However, when our observers go into the classroom and go out to the playground, they give overall ratings that indicate that our intervention children are less aggressive and disruptive in their actual live behavior. We find that parents and teachers both report that the children are improving in their problem behavior, and, in a key way, we are finding that those classroom sociometric ratings are indicating that our target children are becoming somewhat less disliked. That is an important correlate of these children's problem behavior. We feel that this is a key part of what we want to accomplish at the end of this first-grade year. We have started a trajectory with the children that shows some positive social groups in the children and some beginning changes in the parents.

In terms of the implications for community violence, it is early to comment, but we do feel that the developmental trajectory leading to antisocial, violent behavior for the high-risk children may be altered. We are seeing early signs that are optimistic. Second, due to the universal prevention effects that we saw in the classroom with the PATHS program, where we see reduced aggression and more positive peer relations across the board, we feel that there is a possibility of population-wide reduction in the incidence of violence in the neighborhoods over time. The third issue is more clinical and comes up more from our processing of what it has been like within the family. Working with our children early on and increasingly as they get older, we can introduce bridging skills by developing problem-solving skills that are adaptive in school settings. These, in fact, may be different from the skills that are necessary in the neighborhood. A key part of our training with children is to help them to learn the contexts in which certain skills work for them. The ones that we have focused on are the ones that help them to do well in school, in particular.

J. Lawrence Aber: All four presenters did more than I could have hoped for in laying out what we currently know about the effects of family and community violence on children. They put that in a neighborhood context and helped us frame how community and neighborhood context influenced family processes and child development, and how family- and child-focused interventions can be context sensitive, but work specifically on the subcommunity levels. John's last point begins to sketch the vision, and it is at least one of the things that I would like both to get presenter reaction to and your thoughts about, which is the question of whether it possible to think that universal types of preventive interventions like John described would be able to create

Community Violence and Substance Abuse

population-based changes in the probability of violence later, without addressing some of the community structural and functional processes that Tony raises. It seems to me that we are coming to a realization of the strong commonalities in family- and child-focused interventions that are successful.

The need for intervention, however, so outstretches the availability that even the most powerful interventions raise the issue of whether we could get enough coverage to get population-based change even if there are not changes in community processes. This becomes important in the context of the design of Early Head Start. In a certain way, Early Head Start is more explicit about the relationship between child, family, staff, and community development than Head Start is. Maybe that is because it is starting fresh, and they are explicitly hypothesizing changes at the community level that are necessary to get the changes in the other three cornerstones. Without the community development cornerstone, you are not going to get the child development, family development, or staff development cornerstones.

Felton Earls: What animates my research, at least my concentration on the community as starting point, are two competing ideas. One is objective and the other is sort of militant. The objective idea is that we design research in a way that can tell us whether or not effects at the community level are so important that we need to direct our resources primarily at communities, and less at families and children. We have worked hard to pursue that kind of objective, solid design. On the other hand, I would greatly mislead you if I made you think that I was objective as a researcher or a citizen. Peter Tosch probably said it best: There can be no peace without justice.

In a sense, what drives the concern about neighborhoods is their decline. Over the years, there is a loosening of the social fabric, a diminution of civic traditions, and a disinvestment from children. Part of what we are trying to do is to document that. In fact, we already have some evidence that every type of neighborhood in Chicago is declining. Some are starting from high levels, some from low levels. We have a process of decline that suggests that if we do not pay attention to this decline, what we are doing at the family, school, and individual child level is putting children from intervention programs back into a stream that is conditioned to decrease the quality of life.

John Lochman: I would echo Tony's points. I think that in FAST TRACK, if we had felt several years ago that we were competent at producing neighborhood change ourselves, and if we thought we knew what to do with that, it would have been a part of the program. It is a limiting factor. We run into it every day when we are working with our family coordinators, who go out and work with the families in their homes.

The other thing I would mention is that there is a young investigator who has worked with me on another project recently named Terry McCandees, and as part of our research she had used the neighborhood walk methodology to look at neighborhoods. One of the factors she found most related to young adolescent positive adjustment was the presence of resources and activities somewhere in proximity to the children. Places they could go, such as a community center, or things that they could do were related to positive identity development. One of the problems with violent neighborhoods is not only the violence there, but that it helps to eliminate children's access to these positive activities and resources, making it a double problem.

J. Lawrence Aber: These comments suggest that those of us in early childhood programs in a community context look to other kinds of policy research and service research traditions. There is

a large group of initiatives around the country called Comprehensive Community Initiatives for Children, Youth and Families. There is also a thing called the Roundtable for Comprehensive Community Initiatives for Children, Youth and Families, which tried to meld these two together. It is coordinated by the Aspen Institute. On John's second point, there is a whole set of interests now called primary services, such as the decline of recreation and cultural resources in communities. If there are resources, they are often remedial rather than primary. The Chapin Hall Center for Children at the University of California is dealing with those. A vision is beginning of how to put some of this together.

Audience Questions and Comments

Question: How will welfare-to-work programs affect parent/child relationships?

Felton Earls: The larger question is how policy transformations affect the availability of parents to interact with their children. I see welfare reform as part of a larger system of reforms that are making the interaction between adults and children increasingly rare. Some people call it time poverty. In wealthier neighborhoods, parents are not there because they are working long hours and both parents are working, and in poorer neighborhoods, they are not there because they have to travel a long distance to get to work. Some of the maps we make are how far people work from where they live. It turns out that poorer people who live in the inner city have to travel to the suburbs for jobs, and people who live in the suburbs are occupying administrative jobs that are located in the city. Transportation out of the city into the suburbs is much more complicated than transportation into the city. The trains run into the city in the mornings and out of the city at the end of the day. Therefore, another parameter about welfare-to-work is that it is probably going to force people who live in the city to travel great distances from where their children are.

John Lochman: A key issue is how much support there is for good child care, from Head Start to school programs for children in elementary school, to mitigate some of the negative effects of the parent not being there. There can still be good monitoring of children's behavior and some good protection. The likelihood of that happening is not very clear.

Laurie Miller: I just wanted to echo that point from our study. By working with the parents and helping them feel competent in their role as parents, many of them in a small sample have begun working for the first time. Some have left abusive husbands. Others have found better housing. These can be positive effects. If they were forced to do something that is not fulfilling to them, it is not going to make them feel competent. Then you can imagine a lot of negative consequences.

J. Lawrence Aber: The National Center for Children In Poverty has a project on Children and Welfare Reform. Please let us know if you would like information. In addition, the Ford Foundation and the Casey Foundation have neighborhood family initiatives: There are 99 enterprise communities and six empowerment zones that are major federal policy initiatives. The one in Chicago, for instance, deals with issues of community development and human development, and the practical ways of relating to city management.

Community Violence and Substance Abuse

■ Addressing Violence in the Community Part I: Violence-Prevention Strategies

Chair: Monique Better

Presenters: Faith Samples, Marianna Gaston, Beverly Jackson, Brenda Jones

Monique Better: Our project title is "Family Foundations." We looked at children's exposure to violence in the home and in the community and compared it with parent-reported behavior problems.

Parents, children, and teachers were all part of this study. We looked at parents' support systems and what they reported in terms of their own household environment and their depressive symptoms. We looked at children, their social problem-solving skills, and their reported exposure to violence—what they had seen or witnessed in the community, or had actually experienced themselves. We also talked to teachers to see whether they reported children as having the same types of behavior problems that parents reported.

The more parents reported conflict in the home, the more behavior problems were reported for the children exposed to such conflict. Based on this evidence, for the initial part of our intervention study we took a sample of 40 children exhibiting problems and did individual behavior management plans that worked on their aggressive behaviors. Then we divided the children into two groups: 20 control and 20 intervention. The 20 in the intervention group received the I Can Problem Solve curriculum (ICPS), a cognitive social skills curriculum that helps children to generate alternative solutions to social problems. It helps them to recognize their emotions and the emotions of other people, as well as the consequences of their actions. It also teaches some basic word language. The curriculum was implemented classroom-wide.

We also had a parent-training component for this program, where parents agreed to learn how to deal with their children and how to do behavior management. Very few parents came to these groups. We learned that parents had many things on their agendas. We also had parent mentors who went out to most of the homes and worked with the parents on a weekly basis on the problems that they were having with their children.

We are finding that over the course of the year, children did decrease their aggressive behaviors. We are still doing some of the post-test analysis at the end of the Head Start school year. From what we have observed, as well as from the reports of the teachers, we are seeing improvement in behavior patterns. This was a pilot project, and, based on the results that we found, there are things that we will hopefully do again. Overall, what we are trying to do is to look at ways in which we can help children, parents, and teachers deal with children's aggressive behavior.

Marianna Gaston: The National Center for Children in Poverty at The Columbia School of Public Health has been assessing our program, Resolving Conflict Creatively. We wanted to reflect on how our relationship has worked and on what we have done to make the relationship between the practitioners and the researchers more effective.

The Resolving Conflict Creatively program has been working in over 100 schools in the New York City public school system for 11 years, but there are over 1,000 schools in New York. It is a successful and embracing program that people really want, but we are still a small intervention. The focus of the program is learning the skills of conflict resolution and looking at issues of diversity and prejudice in the context of conflict resolution. We train teachers to, in turn, teach a curriculum in the classroom with their students, teaching them the same skills that they learned.

Part of what enables teachers to do this is to consistently visit them in the classroom and problem-solve with them on how to use this curriculum with their students.

We also train peer mediators. Usually it is the older children in the school, like fifth or sixth graders, who are trained to be mediators for the rest of the school. They are on duty during their lunch hour to mediate disputes between other students. They become peer leaders in the school, as well. We train parents in the skills of conflict resolution to use at home. We give parents the same skills and perspective that the teachers are given except to apply it directly with their children. Finally, we train the administrators of the school. We are trying to make a comprehensive impact on the school.

Schools, and New York City schools in particular, are very apprehensive about researchers. They do not want to be looked at, assessed, and told that they are not doing things correctly. That is what they hear all the time, even without research being done on them. Since the schools were apprehensive, we needed to build a relationship of trust. Our program has developed a consistent relationship with the schools that enabled us to be the bridge between the schools and the research team. It took a while for them to realize that they were not being evaluated on everything that they did, just on the issues around conflict resolution.

The question of trust was not only in terms of researcher and schools, but it was also between us. We, the practitioners, do not trust researchers, and so we try to figure out what they are trying to get from us. We feel that we are opening our hearts, our doors, and our subjects, and they are going to get something from us. What are we going to get from them? What do they want to look at, and who do they want to blame in the end? We are trying to figure out how to keep from being blamed and how to keep children and families from being blamed for exposure to violence. How do we look at our intervention in a way that is looking at what we actually do rather than just in terms of aggressive behavior or nonaggressive behavior. That was a discussion we had, where we worked through a lot of difficult things in relationship to what instruments to use and what to measure in terms of our program.

We decided as a program to be very proactive with the research team in terms of everything that was going on. We did not want them to do anything that we did not understand. We asked questions and demanded explanations. We thought that made it a more successful process.

Another thing that was very useful was using the skills of our program in our relationship, as well. When there were moments when we were at an impasse, we had to undergo serious negotiation. We had to walk ourselves through the process to come out with a creative solution, where we all could feel good about the outcome. We needed that several times throughout our relationship. It was a useful perspective for practitioners to realize that researchers can undergo some process with us. We do not have to submit to what they think is the right thing to do in evaluations. In addition, they do not have to feel that we are accepting whatever the experts say that they are going to look at. We worked well in terms of figuring out how to get both of our needs met. As the program people, we felt that they were respecting the parameters and the perspectives that we had, and at the same time, we were able to appreciate their needs and to accept their perspective. It helped us to understand the role of research in terms of how our practice happens.

Faith Samples: I am director of research for the evaluation just described. I will not spend a great deal of time talking about the evaluation itself, because one of the research assistants on the project and I presented posters on that. We talked about both the role of ethnicity in the relationship between children's cognitions, behaviors, and psychological symptomatology, as well as

Community Violence and Substance Abuse

looking at those relationships within the context of the classroom. If you are interested in the evaluation, we have copies.

What we found unequivocally was that practitioners and researchers come to collaborative relationships from different points of view. Marianna summed up well what we experienced, and I will give the researcher perspective on it. We came to the relationship with the practitioners, having established in varying degrees relationships with schools that we would be working with over the course of two years. We knew as researchers coming in that the best way to access samples for study is to go through community-based organizations. They had relationships with schools that made it easy for us to work through them to gain access to schools, students, and teachers. There were also issues of new schools coming into the program that they had not worked with quite so closely. They were very interested in representing the interests of their clients. We, too, were interested in not harming children, and not offending teachers and school officials. At the same time, we were very much interested in maintaining the integrity of the study that we had designed to evaluate the program.

What we found in working with the program staff was, from our perspective, a lot of tension about the need to protect the clients. We did not think that we were horrible people because we were researchers, but we were often viewed that way. As a group, we felt ourselves to be somewhat unique. We were parents, aunts, and uncles of little human beings like the little human beings we would be studying. We all had a sense of the fact that children had experienced a lot, but also believed that children were resilient and able to withstand the nature of the questions that we would be asking.

There was a great deal of concern about the protocol of questions regarding children's exposure to violence. We had very intense discussions about whether or not we should use these measures. Ultimately, we realized that it was the program staff's decision. We argued, as researchers, about the relevance of those measures being included. We were not able to include them, not only because the program staff was not comfortable with them, but also because the schools, teachers, and parents were not comfortable. A concern for all parties had to do with blame. No one wanted to be blamed. We were not interested in blaming anyone; we were really interested in learning as much as we could about what children experience that impacts their lives. The extent to which those things have an impact on their lives will influence how children interpret what they learn in a conflict resolution program or a violence-prevention program.

Therefore, it was our goal to try to understand the nature of children's experiences so that we could then better understand who the program worked for and under what conditions. As children come from varying backgrounds and experiences, it was important for us to try to get that information. We were not able to do that as directly as we would have liked. It was something that we needed to discuss with the program staff, and we agreed as a consolidated group that it was something that we could not do. We accepted that, and we moved forward. However, it brought up issues of how to engage in a collaborative relationship where there was not a great deal of trust because we were researchers or because we wanted to ask questions that we believed the children could withstand.

The issues of trust permeated the relationship for a good part of the first year of data collection. We had our field staff in the schools, and they had to establish a relationship independent of the relationships that the practitioners had established. The field staff were representative of the sample that we were studying, which was largely Latino and African American. They needed to not only represent the sample, but also be able to communicate effectively with the teachers and the administrators. There were big issues there that we had to work through, not only with

the school but with the program staff. We had problems around them being able to trust us in the schools, and with the schools. We did not always see eye to eye on whether or not they thought it was a trust issue, but ultimately we agreed that it was an issue of trust. They were protective, and they thought about children and schools in a way that we as researchers did not. We did have different perspectives about the work that we were doing and how we were to go about it. In some of our discussions, we needed some of the conflict resolution skills that they were teaching.

By the end of the first year, we were all very tense, and as calm as we tried to be, it sometimes was a little out of control. So we had a few sessions where we calmed down, jotted down our notes, and debriefed ourselves, just so that we could keep in touch with what we were doing and where we were going. During the second year of the study, which is now ending, we found that the relationship has been smoother. Of course, our first year was also more difficult because we had issues such as introducing the protocol and moving into the schools. The relationship has grown considerably better over time. Part of it has to do with the program staff realizing that researchers are not all bad people, and we are not interested in studying human behavior because we think that people are different from us. They realize that we are interested in children not only as subjects, but also in terms of their well-being and the quality of their lives. Both the program staff and the researchers came to an understanding of how children's experiences need to be understood so that we can design effective programs to deal with the behaviors that we are seeing in children. To the extent that we had that interest and commitment to the quality of life that children have, we were able to work effectively with the program staff.

Beverly Jackson: I will be presenting for Hope Hill. I have the opportunity to play two roles. One is to talk about the nature of the interventions in the District of Columbia, and another is to talk about the major "policy disconnect" between the numbers of children who are exposed to violence and the investment in and access of practitioners to programs that work on issues of children and violence.

Therapists, as well as people who help practitioners, understand the importance of certain types of environments. One of the keys in working with children and violence, whether you are dealing with issues of prevention, intervention and treatment, or psychosocial development, is that it does not matter what strategies you use or what you bring to the table if the children's environment cannot be made safe. It does not matter what the age of the children are. If you are doing conflict resolution programs in the schools or in preschool, but you are only doing it in the classroom, and the playground is bully heaven, it does not matter what you are doing. Children will conform in the classroom, but outside of school the realities of society take over. With the exception of infants and toddlers, it must cover more than just what happens in a classroom setting.

Hope's first program in the District of Columbia was a crisis intervention program with preschoolers, and her first access to children came via the police. The program dealing with urban violence still has access to a number of programs in communities or subsets of communities in the District of Columbia where there have been large outbreaks of violence. The following is an example of one of those communities. The opening day of swimming season, a young person who had been slighted by some other children decided that he would open fire on the swimming pool. That created a great deal of fear among the children who were at the pool that day, as well as other children within the community. You cannot separate what happens at the pool with what happens two or three blocks away where children might live, even though they may not have witnessed it. Those who witnessed it were harmed. Those who heard about it from those who wit-

Community Violence and Substance Abuse

nessed it were harmed. It set up an environment of fear. For that community it reinforced an environment of fear because in early spring there had been six teenagers killed within an eight-block area. That is an example of chronic violence.

The team from the urban violence program went into all of the child care programs. They worked with the teachers, with the parents who would come in, and with the children themselves. They had access to all these via community policing programs in that area. There is no automatic way in which programs can get access to therapists or intervention teams. Very few communities have actually set that up. That is another example of a "policy disconnect." Even people who are policy shapers and who look at where the funds go, and those who are aware of violence, still often do not put an emphasis on making those tie-ins with programs, even though some of the information is out there. One of the reasons for the "policy disconnect" and the lack of planning and the lack of ease with which people can have access to programs or programs can have access to specialists is because there is not enough information about the impact on children. We have the information, but it is not getting out to the parents, to the child care providers, to the center directors, to the Head Start grantees, or to any of the programs that are in the communities.

After serving in a variety of communities within the District of Columbia, Hope was then invited to work with our Department of Recreation. We have a lot of child care programs through the Department of Recreation—28 to be exact—all NAEYC accredited. The team began working within that system, covering the city. Every pocket of the city has been and is continually visited by violence. Whatever kind of violence it is, it is violence, and it has an impact on children. Hope has become part of the Head Start system and will work with our largest early care and education component, which includes Head Start as well as child care grantees within the District of Columbia.

Access to programs is ongoing because of the extreme need within the city. It is important that she have access to programs city-wide, not just in one small section or one small sector of the city. She has been able to work through the police, one of the major departments of the city, and through the major Head Start grantee. It is important to realize that practitioners cannot easily get access to programs where children have needs and that program directors may not have access or know where the clinicians are. There is a often no connection between clinicians, therapists, practitioners, and people who are actually on site with children and families, as well as a "policy disconnect" in terms of thinking of ways to link the two.

Since 1988 we have had a growing body of information about the impact of violence on infants and toddlers. Those who are in Early Head Start also need to be thinking about what you can utilize within your programs to insure that they are not only safe havens, but also that they have a variety of practices that can build self-esteem in infants and toddlers. If there are toddlers who have violence within the family or violence that they have witnessed, they need special care. There are things that you can do in the program, but there is also a need to find ways that these toddlers interact with therapists and practitioners to enable them to deal with identity formation at that stage in development. Violence has a critical impact on identity formation. The aggression that we were talking about often is related to children defining themselves and their world in terms of victim or victimizer. That is the way in which children view the world around them; how others will accept them or reject them; how they will protect themselves from others or welcome others into their lives. That starts in infancy. This is a critical issue for your programs whether you are Early Head Start, Head Start, or Head Start Transition.

■ Addressing Violence in the Community Part II: Strategies for Helping Traumatized Children

Chair: Gloria Johnson-Powell

Presenters: Gloria Johnson-Powell, Celestine Diggs-Smith, Beverly Jackson, Beverly Langford-Thomas

Gloria Johnson-Powell: Today we are going to talk about how to treat children who are victims of violence. I want to begin by sharing with you some of the consequences for children of violence from a clinical perspective, and also from a personal perspective. When I was four years old, and my younger sister was two and one-half, she was kidnapped from the bed beside me. I was fast asleep. What I remember vividly is that once my sister was discovered to be missing, the adults in my world took over. They were competent, the police were called, and she was rescued. For the next three weeks I remember that we all slept in my mother's room on a mattress and had fun being in the same room. I guess she was afraid to let us out of her sight and wanted to make certain that we all felt comfortable and safe. She certainly made us feel comfortable and safe in a situation that should have been very traumatic. I should remember it as the most traumatic experience of my life. However, I remember that only as a blip on the screen because the adults took over, and I did not have to take over. The adults were very competent and nurturing. During that period, they were observant of us to make certain that we were feeling all right about it. They were taking care of our needs.

The second experience that I had was raising our children in Uganda during the reign of terror of General Amin. I have lived through five coups in Africa and have experienced a great deal of violence as a parent raising children. The scariest part about Uganda was that the children were at the International School, which was right behind General Amin's barracks. If there were a counter-coup from Milton Obote, who had been disposed by General Amin, the center of the fighting would take place around the barracks of General Amin. Our children would be in the crossfire.

There had been difficulty the whole year that we were there. The dean of the medical school and his family were murdered, and their bodies were found floating in Lake Victoria. Two American reporters who came to investigate rumors of a slaughter in the army were found dead. A seven-year-old child who was admitted to the inpatient child psychiatry unit that we created at the hospital had stumbled across the mass grave and presented symptoms of complete hysteria; he was hysterically blind, deaf, and mute. That lasted for six weeks before he finally was able to tell us of his traumatic experience. He had been playing in a field where the bodies had just been barely covered. He stumbled upon the mass grave and recognized his cousin. He realized that that was where the soldiers had been killed, and he knew that if he told anyone that his life and his family's life were going to be in great danger. What I remember about that year is the soldiers pointing guns at our children's faces on the way to school and cars being stolen from all of us. We never knew when a drunken soldier would come upon us and take our car, but hopefully not our lives.

That was when the community of international diplomats who sent their children to the International School banded together. Since I was the child psychiatrist, I was in charge of looking at the trauma the children might be experiencing. We went to the school and provided first-aid instruction to the teachers in case they were going to be there by themselves. We had blankets, food supplies, and medicine. Each week, two of the parents would take turns being at the school with the teachers so that they would always have extra hands. We set up a communica-

Community Violence and Substance Abuse

tions system to work out getting the children away in case the coup started. We had the children practice what to do if firing began.

I mention this because when the big earthquake happened in California, what the researchers found was that the fear in the children was attenuated after the earthquake by having earthquake drills and having the children practice what they would do if another earthquake came. Once they instituted the earthquake practicing, the fear in the children began to decrease because they had some way in which they could cope with it. But more importantly, they had adults who were training them how to act. They knew that adults would be there to help them deal with the situation. Indeed, I heard my own granddaughter say to me, "And you know, Nana, we practiced for the earthquake in case it is going to come. And I am not afraid anymore."

I have learned what things are important not only from my own experiences as a child, but as a parent dealing with trauma and as a clinician working for 15 years as the director of a sexual-abuse and a child-abuse program. One of the things that is extremely important is that children feel that the caretakers in their lives are competent and can handle the emergencies and the situations that will occur. They need to feel that they will not be left to their own devices to do the problem-solving. Second, they need to talk about the trauma—to do some cognitive structuring about the trauma and to talk about it in terms of how it makes them feel to be afraid. I know we just had one panel discussion where there was some controversy about going into the schools in New York and looking at children who had been involved in violence. One of the most therapeutic things that occurred for our children who had been sexually and physically abused—and certainly at the International School—was having the children talk openly about their fears. In doing so we then were able to create recreational programs in which parents were involved to help the children feel that the experience was somehow being taken care of and that they were not in it alone. We discovered that if there was not a nurturing caregiver before the trauma, then the effects of the traumatic experience would be felt more acutely. The children lack the attachment to a primary caregiver that would help mute the experience for them and provide some resources to fall back on.

The children who were at the infant orphanage in Kampala, Uganda, were orphaned because of war and the government killing their parents. We found that having people come in every day to hold the babies and serve as their primary caretaker was essential in the same way that Spitz found that in the infant orphanages, even though children were getting good medical care and food, it was meeting their need to be held and to be nurtured daily that saved them from the anaclitic depression that would eventually lead to their death at six or seven months of age. The effects of trauma on infants and toddlers, and the distancing from a continual nurturing caretaker, is something that we must be aware of as we deal with the Early Head Start program and the effects that it can have on infants and toddlers. Although we focus a great deal on what to do for children in terms of their facing violence, we need to help parents learn how to deal with their children as they face the trauma of violence.

Several years after we had left Uganda, I was talking to some friends about what our children had seen. They had seen General Amin's army surround our neighbor's house using machine guns. They had guns pointed in their faces. Their father and I were worried that the experience that we had hoped that they would gain from Africa might have been destroyed by all the violence and the tensions that were there. The children said that they did not remember that very much, just as I do not remember the kidnapping very much. "You and daddy were there, and we knew that you would take care of everything." That kind of faith in our ability to handle difficult situations and to take charge was a comfort to them.

Community Violence and Substance Abuse

Children need competent adults at times of emergencies. We are often in situations where parents are overextended. We need to help parents cope with their children and handle situations, and help the community of parents who are all experiencing violence to form self-help groups to support one another through these times. How the parents and the teachers deal with situations of violence, and how competent the children perceive them will indeed determine whether the experience will be a lasting one or, as it was for me and for my children, another blip on the screen that finally fades into the background.

Celestine Diggs-Smith: The District of Columbia Public Schools Head Start Program serves over 1,600 children and families. We serve children in every quadrant of the District of Columbia. Head Start has an array of services for families, including services to children with disabilities and mental health services.

We have developed a system that teachers can use to access those services for children or families who are experiencing difficulties. Usually the referral comes to us through a teacher report. The teacher will give us an indication that she feels that a child has a problem, has atypical behaviors, or is not fitting into the normal classroom routine. She can describe the behaviors in detail, or she can give us a brief indication that she wants someone to come and observe the child. We then send a disability or mental health specialist into the classroom to observe the child over a period of time. He or she will talk with the teacher, parents, or educational aide who might be in the classroom. Then we contact the parent and make a home visit to discuss the concerns, to find out if the parent has similar concerns, or how the parent perceives the child's problem. From that point, we do a family assessment to see whether or not the parent perceives that the child has a problem. We look at family risk factors: whether or not the environment is unstable, whether it is a two-parent family, and so on. We look at home issues. Are there other caregivers living in the home? Is a parent available to the child psychologically and emotionally? We look at family dynamics, intergenerational issues, the level of parenting skills, and the parent's perception of the child's behaviors. If the parent is in agreement that the child has a problem or is in need of assistance, then the parent gives informed consent that the child can be referred for further in-depth evaluation. We then refer the child to an outside agency for evaluation and therapy. The mental health professional will come into the classroom to observe the child, talk with the teacher, and make recommendations for modifications of the instructional strategies, environment, or interactions with other peers.

I will share with you one of our cases. I call the child A.C. This child was in the Head Start program for two years and is now ending her last year. When I first came in contact with the family, it was intact. A.C. at that time was three years old, with a younger brother who at that time was one. The mother came in to register her daughter for Head Start. She was very informed about Head Start and community services. She was astute about what she wanted for her child. The first thing she told me was that she needed transportation. Most parents do not know that transportation is one of the related services provided for children with disabilities. This parent was aware of that and said that her child had asthma and would not be able to walk to school. She had no medical confirmation that the child had asthma, but we were able to get confirmation that A.C. did have asthma, we provided her with transportation, and she was enrolled in the neighborhood school. The next time I met the mother, she felt that her daughter needed an evaluation for speech. She felt that there was a delay. She was aware that Head Start provided mandatory speech screenings. A.C. did fail the screening, and she was subsequently referred for an evaluation. We met with the mother to review the evaluation results, and then we developed an IEP for her. From

Community Violence and Substance Abuse

that point on, we did not have much contact with the mother. The child began receiving therapy on a regular basis. Other than that, she had age-appropriate skills in every other domain. She adjusted to the classroom well, and the mother visited the classroom frequently. A.C. adjusted very well the first year. What was unusual was that the mother called me four times a week to discuss concerns and issues that were going on in her life. I thought that she was becoming overly dependent on me.

At the end of A.C.'s first year in school, the mother called to indicate to me that she was moving and was going to attempt to re-enroll A.C. in Head Start for the second year. I did not hear from her until the next September, and indeed, she did re-enroll A.C. She registered her in another area of the city and again requested transportation. It would have been provided for her except that A.C. lived half a block from school. There was no reason, according to our guidelines, to provide transportation. Within a week the mother had accessed six different agencies and was able to get one of those agencies to take A.C. from home to school. We noticed that when we started talking to her about transportation, she did not want to give us her address. She just wanted A.C. picked up on the corner. We thought that strange. At this point the mother had a new case manager, and she began contacting that case manager as frequently as she had contacted me. The next contact we had was from the school. The teacher called our unit and said that she felt that A.C. was having some difficulty adjusting in school. The mother was visiting the classroom no less than three times per week. She was helpful and friendly, but the daughter was having difficulty adjusting. The teacher began to notice slight changes in her behavior, and at that point started an anecdotal record. The following are a few entries in her anecdotal record:

First full day. She transitions well; she participates; she is patient with peers. Mother volunteers all day. Within a week, she is quiet for the first half hour. Later she begins to be more verbal on the playground. She begins to giggle. The giggling continues loudly at inappropriate moments during the morning. She is reminded about inappropriate behavior. This seems to make her giggle more. We talked about consequences. About one minute later her behavior escalated. We were going into a transition at this time; half the children went outside, half were inside. This did not seem to affect her. She went to get crayons. I told her that if she would like to go to the art area, it would be all right. I restated something and invited her to come over and talk with me. She began to shake her head and cry. She cried loudly for 37 minutes. She did not stop but would look at me and go back to the art area and just shake her head no. She cried and ~~cried~~ and cried. This is within a three-day period.

We sent in a disability specialist to observe the child. At that point we met with the mother, who indicated that she was living in a shelter. She left her husband because he was physically abusive to her. Both A.C. and her younger sibling were there and witnessed the physical abuse. The mother indicated at that point that she was afraid of her husband. She subsequently moved from the shelter into her mother's home. She explained that she felt that her daughter was having mood swings because she was readjusting to the new situation. She was readjusting to a new parent. By this time her behavior was getting worse. She would withdraw and sit in the corner for long periods of time. She would stare into space. She seemed to be unable to attend to general classroom routines. At that point the mother stopped coming to school. We would call her and she was unresponsive, which was markedly different from her previous patterns.

About a month passed, and A.C. was absent from school for a week. We thought that strange because she had never been absent before. When we talked with her mother, she did not

respond. We talked with the grandmother, who indicated that A.C. was playing in the lobby of her apartment building with another child. She went to get A.C. an hour or so later, around one or two o'clock in the afternoon. She went to get A.C. later that afternoon, at four o'clock, and A.C. was gone. She did not think that strange at the time. By six o'clock she began to be worried because she did not see A.C. anywhere in the area. By 10 p.m., A.C. was still missing. We heard on the news report that evening that a little girl was found in another part of the city, a great distance away from where she lived, and she was naked. She was wandering around very disoriented with no clothes on. She had semen all over her body. They took her to the police station and to the hospital. She was hospitalized overnight, and then she was released back into her mother's custody.

Her school behavior at that point seriously deteriorated, as did her mother's behavior. She would come to the school and would not interact with A.C. at all. A.C. would begin talking baby talk. She would sometimes sit and just rock or stare into space. A.C.'s behavior became so severe that she was hospitalized for a period of time for inpatient treatment. The mother in turn was hospitalized, and they received individual and family treatment. We met with the clinical specialist several times to look at ongoing assessment of A.C. She gave us seven points that she thought were critical that we needed to consider.

One is that in situations like this a very detailed history of the trauma is important. As much information as one can gather is critical to the assessment process. Second, information about all other potential traumas, including witnessing violence between parents or between a primary caregiver and partner is important. As I said earlier, she had witnessed the abuse suffered by her mother. A developmental history is important to understand what the child's behavioral or developmental status was before the trauma. A contextual history is important because it describes current circumstances for the child and the entire family, including sources of stress and sources of support for the parent. Observation of the child's interaction with the parent is helpful, particularly paying attention to the parent and looking at possible sources of pathology or symptomatology in the parent. Some of the parent factors are mother's and father's own pathology and the presence of denial concerning the child's problems. It is important to consider changes in family functioning or family environment. This child moved from an intact family to a shelter to the grandmother's house. There needs to be a relationship assessment looking at the direct relationship between parent and child and those areas that might cause that primary relationship to change.

The other things that the clinical specialist shared with us were issues to consider from evaluation to treatment. There are also seven issues to consider. They are 1) the safety and stability of the current living situation; 2) the age and developmental level of the child before and after the trauma, to determine the developmental issues impacted by the trauma; 3) the quality of the pre-traumatic environment and the likely impact of the traumatic event or circumstances on that environment; 4) the nature of the traumatic event or circumstance—for example, a single episode, acute or chronic; 5) the child's actual and psychological proximity to the events, especially if it was a threat to the primary caregiver; 6) the child's symptom picture, especially how she looked at the situation after the event; and 7) the strengths and protective factors, especially the relationships that would help her to work through the situation.

We are happy to say that she is out of inpatient psychiatric treatment. She returned to the school. She is not at the level where she was previously, and they are not certain how long it will take her to get there. What is interesting, however, is that the Special Education Department was looking at A.C. in terms of eligibility for services. Based upon what happened, they do not think

Community Violence and Substance Abuse

at this point that she is even eligible for services. We do not know the long-term effects of what happened, especially if there is a breakdown in the environment again, especially if the husband/father comes back into the situation. The younger brother at this point is showing severe ADHD symptoms and is being seen for mental health counseling. So we found it interesting that Special Education would not offer any support in terms of counseling at the local school. A.C. is exiting Head Start; and we know that she is going to need some level of support outside of the normal classroom environment. We are hoping that she will come through this intact.

Beverly Jackson: Often there is not an understanding that witnessing violence, experiencing violence, becoming a victim, hearing about violence secondhand, or seeing violent episodes in movies, TV, or the media can have a definite impact on children. This is a relatively new understanding and one that has not been communicated clearly across a range of policy areas in terms of community or early care and education planning, through the schools or in terms of a basic understanding of child development. Because of that "policy disconnect," there is a problem in children getting access to services they need. It is another gulf between people who provide services—practitioners and therapists who provide a range of interventions for children, families, and community—and the people that need them.

Since Head Start has Disability Coordinators, they are able to access some services for the child, but when the child transitions into the public school, there are sometimes such strict guidelines for services that even if you cannot talk, you may be ineligible. Unfortunately, that is the case in the District of Columbia. I worked with children who could not say a sentence at age six or seven, but could not get services.

One reason we have this disconnect is the lack of information about the impact of violence on children. Another reason is that we have not looked at the system of risk that exists in certain communities, as well as the systems of support that are needed to counteract those risks.

I am the Senior Associate at Zero to Three at the National Center for Infant, Toddlers and Families. We have been looking at the impact of violence on very young children from birth to age three. Much of what I am going to say has an impact on Early Head Start, but it also has an impact on Head Start, as well as on transition services. Public policy is driven by social policy. Social policy is based on personal and national values. We do not think children are affected by violence. That is a national belief.

For every child visiting Boston City Hospital for any reason in 1992, they did a brief scan. They found that 19% of the children had witnessed physical abuse, such as kicking or punching. Ten percent had witnessed knife or gun attacks. One third to one half of these events were recent and ongoing. Fifty percent of the witnessed acts occurred in the community; fifty percent occurred at home. That is one small sample. It is in an urban area, but it shows how many children can be affected by a wide range of violent incidents.

Children throughout this country have experienced violence and feel in many cases that adults cannot protect children. If the protectors are aware and have the information about the violence the children have experienced, then they can take on a protective mode; they can provide extra support and shelter for these children. The protectors are not just parents but can be any caregivers the children come in contact with at Head Start, at an early care and education setting, at Early Head Start, or at home. If they have experienced trauma, they feel the protector cannot protect them unless the protectors immediately jump in and surround them and realize that the violent event could be traumatic. If they have no ongoing continual protector, or someone who takes on that role, the trauma can become even more severe.

Celestine discussed this in terms of having no one to turn to. In that case, the mother, grandmother, and father (who was possibly the abductor) were all out of her reach. The mother was severely traumatized. The grandmother was somehow distanced. Thereby, the children, parents, and caregivers had feelings of helplessness. Depending on how things were handled, it may or may not be a life-changing event.

Parents and others in the lives of children must be empowered to think that they can cope with violence. I did a presentation on violence a few years ago, when people were beginning to realize this, with 650 caregivers. At the end I could feel that everyone who asked a question felt that the parents were the enemy. That is something we cannot allow to happen. They were concerned about the children being traumatized, living in a violent environment, experiencing violence, or seeing violence, but they felt that somehow it was the parents' fault. In some cases, it may have been domestic violence and the parents' fault. Because people in the audience were so child-focused, they were not thinking about empowering parents to help the children. There has to be a focus on strength and resilience, and there is a need for a continuum of support and training for families, as well as for caregivers.

This fits into the Head Start model of a multisector approach. Head Start programs are very family-centered with a strong parent involvement component. Trauma and intervention must be looked at in terms of the family. Working with children exposed to violence, you do not change curriculum and some things that happen in the classroom, but rather you look at creating a full-scale safe system or setting for children. We have to look at our own values as care providers and as early education staff, as well as members of society. We also need comprehensive public policy strategies that talk about how people can have access to programs. There is a certain amount of community and programmatic planning that needs to go into having access to people who can work with children and violence.

Hope Hill has done a lot of work throughout the District of Columbia with very young children and violence. Her first point of entry in terms of working with early care education programs, child care, and Head Start was through the police. Now that sounds a little strange. However, in programs in sectors of the community where there has been a great deal of violent activity, we are able to access the services of an urban violence-prevention project through the police. There needs to be planning about the points of access to enable clinicians, practitioners, and others to work with programs with children, staff, and families in the community.

There is a major Head Start research project on violence that is producing a lot of information. There has to be a policy decision to provide access to programs to clinicians and practitioners. There also has to be a policy decision for child care, both for early care and for education settings, through the state and county training services. Sometimes that is not a priority. In communities visited by a great deal of violence, there needs to be training provided to caregivers and others throughout the community. There must be information about, or training in, working with parents of children exposed to violence.

What are the changes that we need to see? The first area is program change. Often when we see children who are very aggressive and do not have problem-solving skills, we think of a treatment to apply to the children, rather than the environment in which the children exist, that might promote behavior change. We also look at conflict resolution in the classroom setting, as well as on the playground. There are classrooms that have great conflict resolution programs, but those programs are not available on the playground and in the rest of the community. Second, family caregiver change is critical, but also empowering. Gloria Johnson-Powell talked about enabling parents to provide support so that the trauma is just a blip on that child's life experience.

Community Violence and Substance Abuse

A blip is a very small thing, but a traumatic event can be completely life-changing, depending upon the child's age, in terms of their identity formation, how they view the world, and how they think the world views them. The third area is community and intermediary change. Intermediaries are those institutions in the community, such as the church or the school, that may have an impact on children or their siblings.

First, we must look at procedures for responding to children and youth affected by violence. These are things that can be done for the child in the early care and education setting. The symptomatic response is helplessness and passivity to support, rest, comfort, food, and the opportunity to play or draw. We respond in a nonjudgmental way so that the child may be able to play, talk, and recreate the violence, and a caregiver may be able to intervene and talk through some of the experiences the child is feeling. Often, people say that a child saw an incident, then they went out and played. What is important is what they played and what they drew.

The second element in the symptomatic response is generalized fear and the need to reestablish the concept of a competent adult. If the response is cognitive confusion—not realizing that they are in a different setting or having flashbacks to the traumatic setting—it is important to give repeated and concrete clarifications for cognitive confusion. If children display a number of symptomatic responses, they need access to professionals who work with children who have been traumatized, especially regarding violent trauma.

It is important to have a good understanding of what happened to the child prior to and during the trauma. Violence is a new element that has been added to the list of things that may create hyperactivity, hyperpassivity, or a whole range of somatic complaints in children. Often, unless they know the history that includes the traumatic event, they may say the child has ADHD, rather than hyper-aggressiveness as a result of seeing his father continually beating his mother, or other violent events.

Gloria Johnson-Powell: Finally, I would like to share with you what the consequences of chronic violence can do to young children. In Boston, we were working with seven Head Start programs, five of which were in an area of the city that was experiencing a great deal of violence, and two of which were in an area of the city where there was occasional violence. We were looking at kindergarten readiness to determine if the curriculum and the kinds of programs that were going on in the Head Start classroom were preparing the children for kindergarten and other things Head Start children needed in order to be ready. We used a protocol that Dr. Roslyn Gaines and I had used in a cross-national study on perceptual cognitive development in Black children in four different cultures. Those cultures were Los Angeles, which is a special culture all of its own; St. Kitts in the East Caribbean; Enugu, Nigeria; and Capetown, South Africa.

We were looking at four year olds and eight year olds. We used the four-year-old protocol with our Head Start youngsters and looked at such perceptual-cognitive factors as auditory discrimination, auditory memory, visual memory, visual discrimination, and auditory-visual integration. Then we used the Peabody Picture Vocabulary Test, but modified it so that it was culture-free. We used embedded figures, drawings that had been used in the INCAP study in Guatemala. Other perceptual tests, including a verbal recall story geared especially to four year olds were also used. We were stunned when we gave the protocol to the five Head Start programs in that part of the city where the incidence of violence was high. First, the attention deficit in these children was phenomenal; they could not attend to the task. Their energies were consumed with resolving the issues of violence that had occurred in and around the Head Start center; three of the Head Start teachers had been involved in a violent episode, and five children had recently

been involved in a violent episode. Second, in a story recall where two boys were playing in a field and three cars went by, we asked, "How many boys were there? How many cars were there? What were the colors of the cars?" We found that the children projected their experiences with violence onto the story. We got responses like, "There was blood on the sidewalk." "The police came with their guns." These were responses to the question that had nothing to do with the story that they were supposed to recall. There was an inability to follow directions. Their scores were low in terms of kindergarten readiness because of the psychological and social impact and the chronic nature of violence on their lives. This was evident both in the Head Start classroom and in the protocol that we gave them to assess their readiness for kindergarten.

Chronic violence in the lives of children that is not attenuated or dealt with in a satisfactory way in which children can feel safe does affect their developmental process, particularly their learning process. As we know, the single most common pathway to adolescent high-risk behavior is early academic failure. If children leave Head Start and go into public school, and are not succeeding by third grade, they take a large slide. They are not prepared to transition from elementary school to junior high school, and eventually this leads to high dropout rates. In addition, we can expect teenage pregnancy to increase. There also will be an increase in violence, delinquency, and all the other high-risk behaviors that we see now impacting future generations of young children. Violence and trauma in children's lives are extremely important because they do affect the developmental sequencing of perceptual and cognitive development so necessary in order for children to achieve in school.

Audience Questions

Question: Have you published the data on these studies?

Gloria Johnson-Powell: We have not published that data because it has been a collaborative arrangement between the Head Start and Judge Baker Children's Center. They have preferred not to have the data published, but to use it as a way to begin to train their teachers and others in how to deal with issues of violence. The other data on perceptual-cognitive development among Black children in three cultures has been published.

Early Education, Child Care, and School Readiness

■ New Kids on the Block: The National Institute on Early Childhood Development and Education/U.S. Department of Education

Chair: Naomi Karp

Presenters: Naomi Karp, Donna Bryant

Naomi Karp: I am the Director of the National Institute on Early Childhood Development and Education, a new federal entity. I will tell you about myself, our vision for our institute, some of the things we are doing, and how I envision our institute fitting into early childhood research and service delivery at the federal, state, and local levels. I have spent the major portion of my professional life working on behalf of children and families with special needs. For the past three years, I have had the opportunity to translate my knowledge of special needs and disability to the general education research community, particularly the early childhood segment. I work at the Office of Educational Research and Improvement, which is the General Education Research arm of the Department of Education. We are not the Office of Special Education programs, bilingual education, or elementary and secondary education.

The National Institute on Early Childhood Development and Education officially began October 1, 1995. The legislation that created the Office of Educational Research and Improvement is actually Title 9 of Goals 2000. Our office was previously called the National Institute on Education. In the 1980s that was dissolved, reorganized, and the Office of Educational Research and Improvement began. In this current reauthorization, Congress wiped out the traditional bureaucratic offices, divisions, and branches. We have institutes on the National Institutes of Health model, but without the National Institutes of Health budget. We have a traditional education budget with a Health and Human Services (HHS) title. Early childhood is a new undertaking for the Department of Education, except for the work sponsored within the Office of Special Education programs. Rarely does one have the opportunity to give birth to a new federal agency. The vision for our Early Childhood Institute is based on partnerships: partnerships with other agencies, schools, educators, universities, researchers, and families. It is also a vision of research that builds on children's and families' strengths. When I began my career as a teacher of children with emotional and behavioral disorders in Arizona, I learned very quickly that I needed partners in the school if I was to survive and if the children were to succeed. I built strong partnerships with the school nurse, the school secretary, and the school social workers. With those three allies, I was able to make it through some very rough days. I tried to bring these principles of strong partnerships with me when I began working for the Department of Education 16 years ago. I will testify to the fact that partnerships are difficult to build and capitalize on in the federal government. It is especially difficult in a research office to build partnerships with families and educators.

General education really needs to look at Head Start and the special education models as ways of working with practitioners and families. Over my years in the government I have seen two partnership models. One is the Lily Tomlin model, which was fairly standard up until a few years ago. In "Is there Intelligent Life in this Universe?" Lily Tomlin described collaboration as "We're all in this individually." Opportunities for partnerships existed, but follow-up was rare. Collaboration was like the weather: everybody liked to talk about it, but nobody really did anything about it. We are now in what I call the Pearl Buck model of collaboration. This is a great improvement over the Tomlin model and is based on a Pearl Buck quote: "If we fail the children, we all fail." We simply cannot afford to fail another generation of children. There is too much at risk.

Early Education, Child Care, and School Readiness

In our Early Childhood Institute, our target population is children from birth through eight years of age who are at risk of school failure because of poverty, language, family, or environmental circumstances and/or disability. Much of what I do every day centers around building a new research program, developing interagency partnerships, and trying to expand the horizons of my staff and teammates. I always try to put children's faces in my mind when I make decisions at work. This keeps me focused, helps me take risks, and encourages me to dream about what might be. I hope you have read Jonathan Kozol's wonderful book, *Amazing Grace*. Kozol's description of the children in the South Bronx makes our institute all the more necessary. Let me explain how putting children's faces into my work is helping shape our research agenda. In Chicago there is a horrible place that too many children have to call home. It is the Cabrini Green housing project. The lives of the children and families at Cabrini Green have all too often been negatively depicted in the media. However, the movie *Hoop Dreams*, about two budding basketball stars, Arthur Agee, Jr. and William Gates, has put real faces on those brutal news stories. I think you have to actually step into those places to understand what is happening in the lives of children and why education has a role in all of the social service and policy decisions that are being made today.

For the children and families of Cabrini Green, and the children in the hundreds of dismal housing projects around the country, we are developing a research agenda rooted in the belief that no child is dispensable, and all children can learn when provided with the right opportunities and necessary supports. These supports must come from multiple sources, both formal systems and informal networks. These supports must come at the earliest possible moment in the lives of vulnerable children. Our research will help us find what supports work best for what types of children and under what conditions. During these times of dwindling resources and increased demands for social services, partnerships among federal agencies are not just a good idea, they are essential. Without partnerships, too many children will continue to fail. The multiple threats of poverty, poor health care, and low school achievement will remain unchecked, and children will continue to live in constant jeopardy. However, schools cannot address these problems alone. There must be efficient use of the money devoted to health, social services, and education. There must be better access to quality services and supports for children and families. The concepts of equity and excellence cannot be applied only to classroom learning. All supports and services for children and their families must be equitable and of the highest quality. Education research, therefore, must be relevant and aimed at making it possible for young people to become taxpayers. The collaborative, multisystems approach to research is of prime importance.

Henry Jackson's quote, "America is another name for opportunity," is losing meaning for too many families today. Eleanor Roosevelt said, "The future belongs to those who believe in the beauty of their dreams." Today, too few children and adults in their lives dream about a bright future. Our job is to try and restore some of that brightness. Hopes and dreams are being replaced by despondency and depression in the lives of the most vulnerable children and their families. Once again, using the children of *Hoop Dreams* and Cabrini Green as a reference point, let me illustrate what I mean. In one scene in the movie, Arthur Agee's mother is decorating a birthday cake for Arthur's 18th birthday party. She is delighted because Arthur has made it to his 18th birthday. She says, "That's a lot to expect these days." That is not a lot to expect. I believe this is a pathetic commentary on American society. These are abnormally low expectations for American families to have. Mothers should be dreaming about what lies ahead in the next 18, 28, 38, or more years for their sons, not marveling at the fact that a boy lives to be 18. Too many families live in fear of young people who use violence as a way to show they are important and

Early Education, Child Care, and School Readiness

successful. Many families live without health care, adequate housing, healthy diets, and other things that create opportunities for successful learning and development.

For these reasons, we envision an early childhood research agenda that will provide strategies for a new society that will foster dreams, turn child care settings into enriched learning environments, make schools safe havens for children of all ages, and enable all learners to be successful. We want to support activities that will provide sound strategies for a new society that will make a place for everybody, not one that keeps everybody in his or her place. For too long, American education has had a flavor of elitism. Students who have been termed at risk are placed at further risk by assuming that the best way to help them is to expect little and demand less. We have underestimated the abilities of so many of our students. We have cheated them of the opportunities they need most: opportunities for curricula that are challenging and rich, and teachers who expect the best from each and every student. Many have been robbed of their self-esteem, and a self-fulfilling prophecy of failure results. Therefore, a correction in course is needed, and is possible if we all work together. Research tells us that when expectations are raised for all students, we raise the achievement level of students. As Head Start advocates have told us, this must begin early in a child's life. Too frequently, we begin to intervene after the downward spiral begins and has taken a firm hold. Our Assistant Secretary, Sharon Robinson, likes to say, "It is attitude, not aptitude, that determines altitude." Thus, our vision calls for us to work with other agencies in order to build success for all learners.

We know that until recently we have too frequently underestimated the complexity of problems and gravitated towards simplistic solutions. The research community has failed to bridge the self-created gaps and talk about the whole child, the whole family, and the whole community, and how they impact on each other. We have tended to treat isolated systems, not underlying pervasive problems. We desperately need a knowledge base that defines the best approaches to coordinated, integrated schooling services. Students cannot meet world-class standards when they have substandard services for their physical, emotional, and intellectual development. The need now is to be bolder, more imaginative, and more holistic in our thinking and our behavior. We also have to learn how to do more with fewer resources.

The Early Childhood Research Institute intends to be a leader in this area. We have begun by first finding out what is going on in our sister federal agencies responsible for early childhood research and service delivery. We formed an Early Childhood Research working group with nearly 100 members from 35 federal agencies that cut across nine departments. We have met with foundations to find out how they set priorities and how we can work together. We have met with people from different state and professional associations to find out how we can jointly craft an early childhood research agenda that would help the states. We want to determine if programs and funding are going to devolve to the states, what role federal research will have, and how we can work as partners with the states. We have produced two interagency newsletters. Our office provides the support for this working group, and our chairperson is Martha Moorehouse from Health and Human Services.

Second, we have begun to jointly sponsor activities with our sister federal agencies. We have a joint project right now with the Office of Special Education Programs and the National Institute on Child Health and Human Development. The National Academy of Sciences is looking at ways to prevent reading difficulties in young children. We are going to do joint activities with the Substance Abuse and Mental Health Services Administration to look at how intensive mental health services and vulnerable families have an impact on the learning and development of young children. We are going to work with the Office of the Assistant Secretary for Planning

Early Education, Child Care, and School Readiness

and Evaluation in Health and Human Services, to look at some of the major long-term federal investments in early childhood programs and find out what we have learned and what new knowledge we can expect to get from these programs over the next three to five years. Then, when Congress says that Head Start gets too much money, we will have documented what we have actually learned from Head Start and what Head Start should provide for our children over the next three to five years. We have a lot of good ideas, but we do not have a lot of money. So we are going to try and figure out how to do what needs to be done as efficiently as possible with other agencies. Our biggest and most exciting expenditure is funding an Early Childhood Research and Development Center at the University of North Carolina at Chapel Hill. We also have a field-initiated studies program. Unfortunately, it is closed for this year. We are in the process of developing a research priorities plan that will go to Congress by the end of September of 1996. We desperately need your help in getting ideas about early childhood research to Congress.

This is a quick overview of how we are trying to give birth to this new federal agency. We are hopeful that its heritage will be one of collaboration and partnerships, and its legacy will be research that makes a difference for young children, particularly the most vulnerable children and their families. Sharon Robinson says, "We don't inherit the past from our ancestors; we borrow it from our children." We hope that our institute will help us all work together to begin to pay back what we have borrowed from the children of Cabrini-Green, from the South Bronx, from the kids right outside this building, and from the comparable areas in your own communities.

Donna Bryant: The Frank Porter Graham Child Center has recently received the award to become the National Center for Early Development and Learning that Naomi's office funded. We are trying to follow the lead that Naomi's group has set of being interdisciplinary, interagency, and inter-university. We want to try to collaborate as much as possible to get the best from our research partners and from the participants who are working with us.

As we developed our proposal last year, some assumptions seemed very clear to us. The early years are very important, and there is a mandate for the center to cover the years zero to eight. There are many factors that place young children at risk, and that risk is complex and multifaceted. There are no quick cures for the social ills that face the families and children with whom we work. Prevention or intervention requires an ecological approach, a whole child approach, a whole family approach, a whole community approach when possible.

There were certain expectations about what a national center should do. Certainly we needed to address the needs of children from an ecological perspective. The issues that are under the umbrella of a national center needed to be of national importance. We wanted to determine the state of the nation on early childhood practices. We have built in some surveys and some synthesis conferences that will try to address major issues about children and families. We want to determine the best ways of translating the research findings for diverse audiences. Having worked with Head Start projects for five years now, it is very clear to me that you need a combination of people to do this. Some of us are better researchers, data collectors, analysts, and design people, while others can take the information and turn it into usable materials, producing videotapes, handouts, posters, and so forth.

Another expectation of our center is that we would develop with diverse constituencies. We have tried to do that in each of our individual projects by developing a national cadre of advisers. We are, with Naomi's help, branching out to include people from other agencies. We are trying to parallel the good work that she is doing, bringing agencies together here in Washington, linking

Early Education, Child Care, and School Readiness

with other initiatives inside and outside of education. We want to draw on interdisciplinary perspectives. Much of our work at the Frank Porter Graham Center in the past has drawn from the expertise of physicians, pediatricians, social workers, educators, and early childhood people. We will continue to do that with the center work. Finally, we want to recognize the social, political, and cultural context of early childhood programs and policies. Sometimes it is hard to think about children, families, and programs long term when funding situations may change. However, we need to plan for the long range because to have effects, we have to have programs that have continuity.

We decided there would be six major themes of our national center. First is quality in early childhood programs. We are one of the Head Start Quality Research Centers, and I am also an investigator in the Office of Educational Research and Improvement (OERI). So there will be an immediate marriage of information across agencies and an attempt to take information to audiences that include Head Start as well as other early childhood providers. Second, we have a theme about transition to kindergarten. A third theme is ecological interventions for high-risk groups. We wanted to conduct research on intervention programs that are promising and to work with situations of families and child care workers that are of national importance. For example, one of these programs concerns home visiting. What do we know about that as a technique for helping families, and what more can we learn about that? Our fourth theme is looking at the implications of our research on policy and vice-versa. The Bush Center for Policy Studies was at the Frank Porter Graham Center in the '80s, and Jim Gallagher and his colleagues have always taken a policy-related approach. Fifth is the dissemination and translation of research into practice. We are trying to make sure that our information does not get published in *Child Development* or *Early Childhood Research Quarterly* and then not go anywhere else. That information must get back to the people who might really use it. The sixth theme is to look at data sets that exist to see what we might learn. There is no point in gathering new data if you can find good information from older projects. The investigators are bringing into this center the data sets from projects as old as the Abecedarian project, where the children are now turning 21, to new projects and trying to find themes across these various projects.

I will now talk about the six research themes and tell you the kinds of projects that are going to be conducted under this new OERI center umbrella. Dick Clifford and Carolee Howes lead the quality area. There is the opportunity to longitudinally look at children who have been in a wide variety of child care programs through a study called the Cause, Quality and Outcome Study, studying 100 centers each in Colorado, North Carolina, California, and Connecticut. The study followed the children at the end of the first year, when they looked at the quality of their centers. They looked at them a year later and then in kindergarten. With funding from this center, we are now going to follow up those children one more year into school. Following that, they will work on interventions to help improve child care quality. They will be using the information gained from the earlier large-scale setting to work on some interventions within child care centers, both in California and North Carolina, and perhaps elsewhere.

The kindergarten transition theme includes another set of studies that builds on an ongoing study that did not have a kindergarten follow-up. The National Institute of Child Health and Human Development, the NICHD, study of early child care has 10 sites around the country. They recruited about 1,300 children five years ago, when they began, and have followed them with an extensive battery of family interviews, child assessments, and observations in their child care programs. There was an assessment at age four and one-half, and another one planned at first grade. With funding from this center, three of the sites—Arkansas, Virginia, and North Carolina—are

going to do some detailed data collection about the quality of the kindergartens that those children go into. Following that, they will develop a transition intervention with children and families to work with children in North Carolina and Virginia to smooth the transition into school.

In the ecological interventions section, there are three studies. One looks at home visiting with children who are diagnosed as failure to thrive. Bob Bradley is leading that study at the University of Arkansas. There is a study that Barbara Wasik is directing to look at literacy programs. Barbara and her colleague Joanne Roberts are interested in looking at the best literacy programs in North Carolina they can find, and follow a sample of children and families through those programs to see what can be accomplished. They will go from there to perhaps developing training materials. I will be working on a study with children whose social, emotional, and behavioral problems at ages two, three, and four are severely challenging to their child care teachers and to their parents. There is a program in Orange County that works with children, families, and teachers who are referred from Head Start, from preschool programs, from day care centers, and from family day care homes. It is a comprehensive program, and some have questioned whether it is replicable. I would like to study that type of program, compared to other less intensive intervention programs, to find out what works best for children and families.

Jim Gallagher is directing the policy area. Jim's work in the first year is looking at policy issues related to quality practices. Because of the Cost, Quality and Outcome Study, he has gone to the four states where we have 100 day care centers to look at the quality of those centers and to look at policy barriers or policy enhancers, to try to connect the data collected with policy issues in those states. For instance, the child care regulations differ widely between Connecticut and North Carolina. With only four states, there is a wide diversity. His proposed themes for later years are transition practices to kindergarten, intervention practices for children at risk, and then, finally, professional development. Peg Birchenal is directing the existing data set analyses and will, of course, help all of the other studies as we generate data over the years.

Finally, an area that all of us need to pay attention to is the Research to Practice Section. As Director, Pam Winton receives information that is usable, helpful, and informative to Head Start teachers, Head Start home visitors, child care workers, family day care providers, and a diverse group of people who work with young children.

That is our challenge for the next five years. We have many partners working with us already. We have a national advisory panel of 15 people. We had our first two-day meeting last month here in Washington. Each of us has an advisory panel on our individual studies, and some include Head Start directors and Head Start parents. Over the next decade, we hope there will be evidence of the productivity of this group that is funded as the first center under the newly reorganized OERI.

Audience Questions and Comments

Question: This question is for Donna Bryant. You mentioned children zero to eight. Is this all children, or is it identified populations?

Donna Bryant: It is identified populations. Bob Bradley's study with Failure to Thrive will be primarily with infants, toddlers, and children up to age three. The kindergarten transition studies will be working primarily with children ages four, five, and six. The follow-up studies of the Cost, Quality and Outcome Study in the NICHD child care study will be looking at children five,

Early Education, Child Care, and School Readiness

six, seven, and eight. There is no single study within our center's umbrella that will pick up children at zero and follow them through eight. The time frame did not allow for that, and it also seemed that questions that needed to be answered did not require samples like that. The NICHD child care study has 1,200 children who have been involved in longitudinal research. We were trying to target specific concerns that happen at specific periods of time.

Comment: My question has to do more with children who do not have identified special needs, or are not identified exactly as being in poverty environments and so forth.

Donna Bryant: Some of the projects will involve children who have been identified for various reasons. The study that I am conducting, for example, involves children who are referred because they are noncompliant or aggressive even at age three. Other studies will select children randomly out of day care centers that range in quality. There are likely to be upper income and lower income families in those samples. So the different studies will pick up different samples.

Question: Will you be able to link with national evaluations of federal programs? I am thinking particularly of Even Start and Early Head Start.

Naomi Karp: We have some literacy books that we produced from a conference jointly sponsored by our office and Even Start. The person in my office who is responsible for literacy is developing a long-range plan, and Even Start is part of it. We know the major programs and try to link with them as closely as possible.

Question: Is there going to be any time in the future when an RFP will start out blending funding streams so that national stakeholders or individual stakeholders are brought together at the beginning?

Naomi Karp: My long-range goal for the interagency working group is to develop a collaborative early childhood research agenda over the next two years. There are several of us who are trying to determine how we can work with the Federal Register barriers that prevent several agencies from actually declaring they will work together. The way we do it is to say that an agency may be interested and, upon funding, will contribute money. I have worked that way with the National Institute of Mental Health before.

Donna Bryant: Head Start has been a good model for adding research dollars to other ongoing projects to achieve a particular result.

Question: I have been wondering whether the National Center is going to work on this kind of programmatic aspect as well as research. One of the main things that these research projects involve is child care in all sectors; however, failure-to-thrive children will most likely not be in any kind of program. Therefore, these children are being cut out at all levels. There is no unified system for them. Will this also be one of the charges of your center?

Naomi Karp: It is what I would like to see. However, since I am in the Department of Education, and there is no national system of education, it is hard to do that. We are trying to go

Early Education, Child Care, and School Readiness

in through the back door and bring agencies together at the federal level and develop solid working relationships.

One thing I did not mention is that in the Office of Educational Research and Improvement, we have a 15-member National Research Policies and Priorities board. Lynn Kagan is on the board, and as long as she is there, there will be a move towards trying to bring the different pieces together. However, it is going to take more than our little institute to do it. We need strong advocacy from outside, as well as hard work inside.

Question: Will sociopolitical realities affect early childhood work?

Naomi Karp: Our institute has not been affected by the Goals 2000 cuts in any dramatic way.

Early Education, Child Care, and School Readiness

■ Head Start: Part-Day Program in a Full-Day World

Chair: Beth Miller

Discussants: Freddie Hamilton, Latifah Hasan

Presenters: Mary Lerner, Beth M. Miller

Children need parents who can work to support them, and they need access to early childhood programs that encourage their development. However, educationally-oriented programs for children are often logistical nightmares for parents who work or are enrolled in education or training programs designed to enable them to become self-sufficient. This symposium will examine how part-day programs like Head Start fit the interface between work and family.

When Head Start was designed, few mothers of young children were in the labor force—especially single mothers. Creating a part-day program made sense then. However, a growing proportion of poor families now have full-time commitments to work or attend school, even though only 25 percent of Head Start programs are open eight hours or more. If welfare reform efforts succeed, eventually most parents with young children will work outside the home. How will they be able to take advantage of part-day programs?

The presentations in this symposium reviewed what we know about employment in the lives of poor families, arrangements that working families make to provide child care when part-day programs are not in session, and innovative efforts to link Head Start with full-day child care programs. The two discussants represented community-based multiservice agencies in low-income communities who help families to both address the developmental needs of their children and become self-sufficient.

Work in the Lives of Poor Families Mary Lerner

The rigid part-day schedules of most educationally oriented preschool programs present obstacles to the participation of children from families with working parents. To an increasing extent, the poor families who are eligible for Head Start and many public preschool programs are attempting to enter the labor force or hold inflexible, low-wage jobs. They find it particularly difficult to manage their work obligations at the same time as they provide their children the opportunity to participate in programs to support their development.

The diversity of family situations in which poor children live contradicts the stereotypes that creep into media reports, the policy debates, and the minds of taxpayers. For instance, many believe that the typical poor child is a member of a minority group whose mother is unmarried, lives in an inner-city neighborhood, and is fully dependent on public assistance payments. An objective look at the data shows that the majority of poor children under six (57% in 1992) live with a parent who works; 18 percent lived in families in which the parent or parents worked the equivalent of full time, and another 39 percent had a parent who worked part time or part of the year. That work effort deserves more attention and support than it typically receives.

The fact that parents in so many poor families are working contradicts the image of the poor family as a young mother watching TV as she waits for her welfare check. In fact, 43 percent of mothers who receive welfare benefits also work during the year, although their earnings seldom lift them above the poverty line, and many are reluctant to lose the security of benefits like Medicaid that are linked to welfare. However, remaining on public assistance is an option that will be much less available as welfare reform takes effect.

The jobs held by many low-income working mothers pose many obstacles, especially when it comes to arranging for their children to attend early childhood programs. Low levels of education consign many to pink-collar jobs in the low-paid service industries, where they are expected to work odd hours and variable shifts. A recent study by the U.S. Department of Labor indicated that one in five full-time workers worked nonstandard shifts, and one third of those workers were women.

Low-income parents value the same child-oriented, developmental features of early childhood programs that are important to all parents, and many are eager to give their children the benefits of attending part-day programs like Head Start or school-sponsored preschool. Although innovative strategies are being tried to link Head Start and child care programs to meet the needs of employed parents, most families now get little help to manage the logistics and stresses inherent in their situation. We owe these struggling families more assistance than they are currently getting.

Child Care Arrangements of Families Participating in Head Start or the National Transition Demonstration Project *Beth M. Miller, Susan O'Connor, Sylvia W. Sirignano, Pamela Joshi*

Out-of-school time is critically important to children's development. It encompasses over 90 percent of a child's time in a given year, and represents the opportunity to learn social skills, develop new interests and competencies, and form meaningful relationships with caring adults. Studies of labor market decision-making find that lack of child care is a major impediment to participation, especially among low-income women. In addition, research on parent satisfaction with child care generally finds higher levels of dissatisfaction among low-income mothers, who rarely feel that they have a wide choice of child care arrangements. For mothers whose children attend part-day Head Start programs or are enrolled in school, additional challenges may be encountered in creating a match between child care coverage and hours of work.

A recent study examined the out-of-school time of children between the ages of four and seven who were enrolled in two federally funded programs: Head Start and the Public School/Head Start Transition Demonstration Project. The study sample, drawn from families in three urban areas across the United States, represented an ethnically diverse population with a large immigrant representation. The majority of study children (64%) spent all of their out-of-school time at home with their mothers (31% of mothers were employed). Of children who spent time in another arrangement, the most common primary arrangement during afterschool hours was care by an older sibling or by their father, followed by other care situations. Looking at all the arrangements during the afterschool hours among children of working mothers, 79 percent of children were cared for by their fathers, 71 percent by an older sibling, 29 percent by another adult relative, 29 percent participated in some lessons or remedial programming, 11 percent cared for themselves or were accompanied by a younger sibling, 8 percent were taken care of by a babysitter, and 4 percent attended an after-school or recreational program.

Most families in the study communities felt that they had limited options for either child care or other enrichment activities during their children's out-of-school time. Mothers who had access to relative care, especially fathers or older siblings, were much more likely to be in the labor force. These findings suggest that when low-income mothers feel decent care is available, they will join the labor force to enhance the financial well-being of their families. However, when such care is not available, mothers are extremely reluctant to leave their children with those they do not trust will provide good supervision. Given the lack of accessible formal child care

Early Education, Child Care, and School Readiness

options in the communities involved in this research, such findings should be seriously considered by those who are concerned with both the labor force participation of low-income mothers and the well-being of children and families.

Working Together for Children: Head Start and Child Care Partnerships *Helen Blank*
Paper summary not available

■ Early Child Care in the Lives of Low-Income Children: A Substudy of Head Start-Eligible Children from the NICHD Study of Early Child Care

Chair: Bettye Caldwell

Discussants: Shannon Tanaka, Joan Lombardi

Presenters: The NICHD Early Child Care Research Network

Bettye Caldwell: Those of us who were around for the first year of Head Start remember the rhetoric, the hype, and the extravagant claims that were made about children who entered Head Start. At that time, the program was for six year olds in half the country, and for five year olds in the rest of the country. Now it is primarily for three and four year olds. The truth is that we did not know what children were like at the point of entry into Head Start then, and we do not know much more today. To get a sense of what the children are like when they are at the entry point, we are going to present some data from the NICHD Study of Early Child Care. The data have given us an opportunity to look at a reasonably good cross-section of three and four year olds, some of whom are from very low-income families, some are from what we might call the near-poor, and the remainder are from our larger total sample. We have looked at the background experiences of these children at the age of three years, their family situations, and their child-rearing histories. We are going to look briefly at what the children themselves are like at this point of entry. It seems to us that this is absolutely critical for any subsequent evaluation of the effects of Head Start. Those of us who are presenting today are in the Head Start Task Force, one of the subcommittees of the Steering Committee. Before we share any of our data, we thought that you should know something about the parent study that has spawned the data that we will report.

To tell you about the background of this study, we are going to hear from Dr. Sarah Friedman, who is the overall scientific project officer of the study at NICHD. She wrote the Request for Proposals and has been involved in every aspect of the project.

Sarah Friedman: The NICHD Study of Early Child Care is a longitudinal, comprehensive investigation of the effects of the rearing environment on the social, emotional, cognitive, and linguistic growth and health of children from diverse family and geographical backgrounds. The study is the largest and most comprehensive ongoing longitudinal study of child development and the effects of child care on such development in the first seven years of life.

I will pose and answer two questions: 1) how did the many investigators who worked collaboratively on this study get together to form a network; and 2) how have the many investigators managed to collaboratively plan and implement such a large study? About three and one-half percent of the total NICHD extramural research projects are initiated by NICHD and are carried out by a small number of NICHD staff in collaboration with investigators in the scientific community. Such cooperative agreements are established to address scientific or important public health concerns that cannot be addressed by small studies. The effects of early child care on the development of children have been studied by scientists for many years, but no one investigator nor one team mounted an investigation that could simultaneously take into account multiple critical family and infant day care variables that are hypothesized to influence the development of young children. Likewise, no one investigator or research team studying the effects of early child care focused on children from diverse family and geographical backgrounds. This is unique to our study. Dr. Duane Alexander, the Director of NICHD, has been aware of the high prevalence of early child care and the concerns of the public regarding such care. Consequently, he decided to launch this comprehensive study about the effects of child care. Early in 1988, NICHD issued a Request for Applications, calling on investigators to participate as members of a research net-

Early Education, Child Care, and School Readiness

work. Of those interested, 10 teams were selected based on demonstrated scientific merit and on willingness to work with a small number of NICHD staff and with each other as members of a collaborative research network. These teams were also geographically spread out across the United States and could bring in families from both rural and urban settings. Recently, the network has been augmented by staff members from the Administration for Children, Youth and Families who have called to our attention the need to do studies that focus exclusively on Head Start-eligible children. Today's symposium is a result of a collaboration between the investigators of the NICHD Study of Early Child Care and staff from ACYF.

The NICHD and the participating investigators have established organizational structures and lines of communication that make it possible to plan one study to be carried out at 10 sites. All scientific plans have been made centrally by the steering committee, consisting of an independent chair person, one representative from each of the 10 grantee teams, a representative from NICHD, a representative from the central data coordinating center, and a representative from the central data analysis center. The 14 members of the steering committee are the collective principal investigators for the study. All the research procedures planned by the steering committee were written out in great detail by network investigators. These are available through the ERIC system to anyone interested in replicating parts of our study and borrowing our procedures for the first three years of life.

The research assistants at the ten data collection sites were trained and certified centrally to assure high standards and uniformity of performance. Data that were videotaped were coded centrally by highly trained coders. The data that were coded live and those that were videotaped and later coded were transmitted to and monitored by the data acquisition center. Data analysis has been directed by subgroups of network investigators and was carried out centrally by staff of the data analysis center.

The many investigators managed to collaboratively plan and implement the study, thanks to their wish to work together, the availability of centralized organizational structures established for the purpose of coordinating important aspects of the study, and the extensive electronic and face-to-face communications. Therefore, this symposium also reveals the workings of an unprecedented experiment in large-scale scientific collaboration among developmental psychologists.

Bettye Caldwell: I would like to add thanks to the families. They have let us into their homes for many lengthy sessions at each of seven age intervals in their children's lives, filled out hundreds of questionnaires, and allowed detailed observations in their child care setting. We would not be able to stand here and talk with you today without the help of those groups.

Deborah Johnson: I am going to add a little more in-depth information to the overview of the study before I present some of the demographics. The NICHD Study of Early Child Care was designed to provide a comprehensive examination of children's lives from birth through first grade. The study describes the complex characteristics of the family and home, of the child care environment, and of the child. Each aspect of the child's environment influences outcomes for children, for parent/child relationships, and for families. Multiple measures of child care environments include direct observations, global ratings of care, and evaluations of structural features of care. The focus is on the child from an ecological developmental perspective. It is our intention to examine concurrent long-term and cumulative influences of the family and child care on cognitive, linguistic, social, emotional, and physical development. The richness of the data set and the number and diversity of infants included give us the opportunity to focus on many specific issues.

Early Education, Child Care, and School Readiness

From an ecological developmental perspective, it is crucial to understand the family characteristics of children in low-income families. Many policies and programs often refer to two-generational programs and include very young children and their parents. Today we present a picture of Head Start-eligible families with children 36 months old, just prior to the point where their child would enter Head Start. Participants in the study were drawn from the NICHD Study of Early Child Care and an ongoing seven-year longitudinal natural history study of 1,364 full-term, healthy infants from 10 sites around the country. Infants for the study were recruited from 31 hospitals over a 10-month period. This recruitment took place within a 24-hour sampling period, in which women giving birth were visited in the hospital. A subset of these families met the criteria for inclusion and were ultimately selected in accordance with our conditionally random sampling plan. We excluded mothers under 18 and children or mothers with health problems at the time of birth. While the sample is not strictly nationally representative, the participants come from major regions of the country, and from both urban and rural settings. They include children of different ethnicities as well as children in single- and two-parent families. The sampling plan insured that recruitment of families included mothers planning to work full time, as well as those who planned to stay home. Twenty-four percent of the mothers planned to stay home, while 53% planned to work full time, and 23% planned to work part time in the first year of their child's life. The recruited families came from a wide range of socioeconomic and racial backgrounds and included 24% non-White families and 11% low-maternal-education families. Thus, families were selected not on the basis of participation in a particular form of care, but with the intention of providing a natural history of child care participation. The intention has been to assess the whole spectrum of child care arrangements, including father care, grandparent care, nonrelative in-home care, family child care, and center-based care.

Participant recruitment started in January of 1991, and data collection on the first three years of children's lives was completed in 1994. In particular, data were collected on children and their families in child care at 1, 6, 15, 24, and 36 months. There has been only one percent attrition over the four-year period. Data for the descriptive analysis reported here are based upon 1,216 children at 36 months, with some parental indices reported at 1 month.

Head Start-eligible children are in families with an income-to-needs ratio of one or below—at or below the poverty line. Within the NICHD sample there are approximately 205 children in this first group, representing the poorest of the poor. About 160 children met our second criterion—families with an income-to-needs ratio of zero to 1.8—the near poor.

The child's family circumstance is an important contributor to child care options and choices. The demographic profile from our data, although not nationally representative of Head Start-eligible and other low-income children, includes children and families from diverse groups served by Head Start and related programs and helps to draw a picture of particular challenges they face and possess. For the whole sample, 76% of infants were White, 13% were African American, 6% were Latino, and 4% were Native American or Asian American. In the poor sample, this distribution changes dramatically. African-American children compose 32% of the total and Latinos about 10%. In the near-poor group, 18% are African American, and 8% are Latino. Means for maternal education did not differ much between the poor and near-poor groups. The ranges for both groups, as well as for the full sample, include mothers who have graduate degrees and mothers who have not completed high school. However, education was distributed differently. In the near-poor group, a higher percentage of mothers had achieved a high school education or better, and many had some college or had completed four years of college. In the poor group, there was a higher percentage of mothers who had less than a high school education. Work patterns were

Early Education, Child Care, and School Readiness

also different in these two groups. A higher proportion of mothers in the near-poor group were employed, and they worked a greater number of hours. Among poor mothers, the mean work time was 11 hours per week, with more than 50% not employed at all. Among near-poor mothers, more than half worked 40 hours per week or more.

Children in poor and near-poor families lived in a variety of family configurations. The most common family configurations were mother-child single-parent households, and two-parent, mother-father households. More than the half of the mothers in the poor group are single heads of household, while three fourths of the near-poor mothers were in two-parent households and lived with husbands or partners. Two-parent households among the near poor are only slightly less common than for the sample as a whole. The near-poor group looked very much like the total sample. Most families with three year olds have three or fewer other children living in the home. Among families at both levels of poverty, it is rare that more than three children are living with them. Despite common perceptions that extreme poverty in families is linked to greater childbearing, in these data we find poor and near-poor families are essentially no different from the total sample in the number of children residing in the home. Consistent poverty experiences in the child's early life and the stresses that are associated with that poverty clearly have implications for intervention. Among those families below the poverty line at 36 months, most were consistently in that status at each prior information-collection interval.

The duration of poverty indicator is clearly the major dividing line between the poorest families and all other groups. Most families in the near-poor group, given the assessment intervals, dipped below the poverty line for less than one year, and during no more than one to two intervals of the study. Still, this group experiences the threat of dipping below the poverty line more often than families in higher income groups. With respect to public assistance, the poor and near-poor groups show different patterns. Below the poverty line you are eligible for services. This ends up being a proxy variable for how we split the groups. Seventy-five percent of the poor group received public assistance, while only 26% of the near-poor group did.

One of the major strengths of the data set is its inclusion of measures that assess psychological processes, as well as child and family adjustment. The following descriptions use some of these measures to describe the child's home ecology, including maternal depression, the mother's Peabody Picture Vocabulary Test, and the HOME. With respect to maternal depression, numerous studies indicate that clinical depression among mothers significantly alters the child's home experience and may have lasting effects throughout the lifespan of the child. A score of 16 on our measure, which was the Center for Epidemiological Studies Depression Scale, is considered in the clinical range. In the total sample, most mothers did not score in clinical ranges for depression. However, poor mothers had higher scores for depression than near-poor mothers. The means for these two groups were higher than for the total group. In addition, the ranges for poor mothers extend further into the clinical range, such that 32% could be categorized as depressed using this scale. Fewer individuals were similarly categorized among mothers in the near-poor group. Because of the nature of depression, children in homes where mothers are depressed experience environmental risk. Understanding the characteristics of families and environments that mitigate against mothers experiencing high levels of depression may serve to minimize risks to children entering educational programs.

As an indication of the home learning skills environment of children likely to be associated with school success, the PPVT, a test of vocabulary and language skills, was given to mothers. Mothers in the poor group had a six- to seven-point differential in means from those in the near-poor group. Ranges for these scores were the same in both groups. The difference between the

Early Education, Child Care, and School Readiness

poor group and the total sample on average was about 17 to 20 points. This finding relates to the child's acquisition of standard language skills, as the mother is an important intermediary environmental agent for language development.

In the final example of the child's home ecology, descriptive data on composite scores of the infant-toddler HOME, the HOME inventory assesses the quality and quantity of stimulation and support available to the child in the home environment. The items of the HOME can potentially tell us about the child's family/home context and whether it is consistent with expectations of formal and mainstream schools. The HOME also indicates what preschool experiences would facilitate smoother transitions for poor children. Our data show that the poorest families are more differentiated by the HOME. Near-poor families do not look very different from the total group on this measure. However, the poor group does. Given the extreme and consistent poverty of some of these families, one might have expected a greater mean difference between the lowest income group and the total sample. This finding suggests that even the very poor families possess many of the family practices, including direct proximal behavioral transactions like responding verbally to children, and more distal features such as organization of a daily routine. Furthermore, many of the HOME items on which the poor and near-poor samples received lower scores than the total have been found amenable to home-based interventions.

In summary, although there are numerous parallels between the poor and near poor, the near poor have many more tangible resources and fewer environmental risks to children. In contrast, the poorest group experiencing consistent poverty is disproportionately non-White, the least likely to have resident fathers or partners, and in most other ways experiencing a lack of resources for their children's success in the future. Despite that, the data also challenge certain myths about poor families and point to enormous diversity within impoverished families. Future research may need to focus on families who have achieved positive outcomes for themselves and their children with few resources.

Louisa Tarullo: Our goal in this presentation is to delineate child care experiences of three-year-old children in the poor and near-poor groups. Families may pass through or shift between these categories, depending on their employment status and other conditions. The poverty line may be a porous border between these groups, and there may be numerous variations among families within the groups. There are distinctions between these groups that are of major importance for program design and operation. While a major goal of the current effort is to draw a picture of children as they become eligible for Head Start preschool programs at age three, another important goal is to understand the child care patterns of children who, while still low income, are not eligible for Head Start services at the moment. It is important to understand the ramifications of welfare changes in the lives of these children and how they may be affected by these changes. As the study progresses, investigators working through the Task Force will continue to examine the care experiences of Head Start-eligible children, both those who actually enroll in Head Start and those who do not. Data collection is currently under way for these children, who are now four and one-half. As part of our interagency agreement, we will be analyzing data about both their Head Start experience and other child care arrangements.

We are going to focus on a select number of variables that are designed to give you some basic information about type, duration, intensity and quality of child care experienced by the children, mostly at 36 months. On first entering care at six months, close to half of all the infants in the study were cared for by a relative. By 36 months, there is a shift to more formal arrangements, including child care centers and, to a lesser extent, family child care homes. This shift had

Early Education, Child Care, and School Readiness

occurred already in large part by about 15 months. For the near-poor group, 30% used centers and 25% used family child care homes. In-home care was the least likely in the near-poor group. Grandparent care was equally likely, around 15% for both the near-poor and the poor groups. Fathers were used more by the near-poor families, as they were more likely to have a father in the home. Though poor mothers were the least likely to work, they used only slightly fewer hours of child care than the near-poor group. We want to find out what these mothers are doing, if not working outside the home, that they need child care. Perhaps they are in school.

For the poor group, the mean for child care use is 34 hours per week, which is close to the mean for the total sample. For the near-poor group, it is 36 hours. On average, most low-income children are in what we define as full-time care by age three. Regarding onset of care, the children in the poor group tended to enter any type of care around seven months compared to five and one-half months for the near-poor group. On average, poor children entered full-time care at about eleven months. Near-poor children entered care about four months earlier than children in the poor sample. In view of the emphasis placed by many psychologists, psychiatrists, and pediatricians on the importance of uninterrupted contact between mothers and infants during the first year of life, an importance not consistently borne out by empirical data, this is an interesting finding. It is one of the few findings we have in which the poorest group showed, on average, a more desirable pattern in relation to the near-poor group. This is a point of departure for intervention programs. The group of mothers with the least education and possibly the strongest need for support in their parenting are more likely to be available for home visiting and other types of early intervention efforts. If welfare changes require them to be working by the time a child is 12 weeks old, this won't be possible.

One indicator of stability of child care is the number of starts of child care arrangement. Children in the near-poor group are more likely to have multiple starts. Fifty percent of the children range from between three and eight starts during their first 36 months. The average child had at least five starts, and close to six for the near-poor group. Given what we know about the importance of stability in children's lives, this lack of continuity is of concern. It is of particular concern when it may correlate with other instances of family instability, such as moves and job shifts. From what we know of working conditions of parents just above the poverty line, employment is not likely to be stable. Continuity of care may be suffering as a result. Changes may also be due to shifts in eligibility for certain types of child care subsidies, which are tied to parental employment and training, rather than geared for providing seamless care to children.

The next variable is the number of different child care arrangements children are in at 36 months, including multiple arrangements within a week or within a day. The poor group is more likely not to have any child care arrangements: 16% of near-poor children have had two or more arrangements, while only 12% of poor children are in that category. Interestingly here, having more than one arrangement does not appear to be particularly linked to income, since 26% of the total sample falls into that category. This is more of an indicator of how parents across all income groups pull together different kinds of arrangements, formal and informal, to cover their needs. In summary, we see that the near-poor group is more likely to enter care earlier, especially full-time care, more likely to have multiple starts, and more likely to be in multiple arrangements at age three than the poor group. Whether these measures of child care participation are cause for concern, however, is related in part to the quality of care the children are receiving.

We then looked at two measures of quality of care: structural and process. When children were in multiple settings, the one in which the child spent the largest amount of time was the one that was observed for the quality measures. Seventeen percent of child care arrangements across

the whole sample were not observed. There is a possibility that quality may be related to willingness to be observed. We know that at 36 months children in the unobserved group had a significantly lower income-to-needs ratio and lower maternal education. They are more likely to be living in the South. They were also more likely to be in family child care or relative care than in centers. While these children may be in more at-risk environments or may have lower quality of care, it is premature to reach these conclusions prior to further analysis of subgroups. What we can say is that the following data represent the child care settings that were open to observation by the experimenters in the study. Structure has often been used in determining child care quality, but more recent research has shown that it creates a context that allows for the development of better caregiver/child interactions rather than a direct factor leading to improved child outcomes. In terms of the child/staff ratio, the poor group looks more like the total sample, with a mean of 4.6 children per adult. The near-poor group actually has a better ratio, less than four children per adult. These levels are better than the level recommended by the NAEYC. The near-poor group is less likely to have a caregiver with formal training in the care of young children. The average caregiver in the poor group and total sample has at least a certificate of vocational training. For the near-poor group, the mean is below high school completion. These findings seem to contradict one another and are a little difficult to interpret. In the near-poor group we had a better child/adult ratio, but that group has caregivers with poorer qualifications. These data confirm what many of the country's leaders in child care have long suspected: quality is bimodal in relation to family income. Most of the programs developed to serve very poor children and their families must meet fairly stringent recommendations for funding. Child care programs attracting more affluent families are likely to be those that strive to meet recommended standards. Services available to near-poor children lack the advantages of either of these incentives: the necessity for higher qualifications to receive federal money or for higher qualifications to attract more affluent clients. Thus, they do not provide these quality indicators. The data on child/staff ratio do not fit this interpretation. One explanation we have may go back to is the type of care that we saw initially, because the families in the near-poor group have a greater reliance on small-group, low-ratio settings, such as father care and family child care homes.

Two measures of caregiver/child interaction, their positive caregiving frequencies and a global positive caregiver rating, were obtained by means of direct observation in the child's primary child care setting with a procedure that was developed especially for this study. The Observational Record of the Caregiving Environment (ORCE) was designed to measure the quality of caregiving for the individual child of interest, including attentive and responsive care, positive affect and affection, lack of restrictive or intrusive behavior, and activities that promote cognitive and social development. The ORCE ratings were based on four cycles totalling 44 minutes each, made during 2 days of observation.

We find that the caregivers in the poor group score slightly lower than either the near-poor group or the sample as a whole. Neither low-income group showed ratings at the very highest end of the scale. These are discrete behaviors by caregivers and caregiver-child interaction that are considered indicative of quality. As we look at more global ratings, we find the mean for the poorest group is just above the indicator for fair. For the near-poor, it is only slightly better. The sample as a whole has a mean midway between fair and good. Interestingly, for the total sample, the middle two quartiles are both better than fair. For the poorest group, a full quarter of the sample lies between fair and poor, and another quarter of the sample is between poor and terrible. These findings suggest that while children in poverty have caregivers with more formal training, they are disadvantaged in having higher child/staff ratios and less desirable caregiver-child inter-

Early Education, Child Care, and School Readiness

actions, both in terms of frequency of positive behaviors and more global assessments of quality. Further analyses that include data on costs and subsidies, may help to unravel these inconsistencies. Other research has shown that the group on the brink of poverty is the least likely to receive child care subsidies. Transfer payments or earned-income tax credits are usually used by middle-class families. Families in poverty or near-poverty are also more likely to spend a greater proportion of their incomes on child care, although their actual child care costs may be lower.

Low-income, single mothers represent a special group of interest, one which past research has shown are often the least satisfied with their current child care arrangements. Our questions are extensive, and their importance for policy decisions cannot be overemphasized. We need to look more carefully within low-income groups to better understand both their risks and their resiliencies.

Betty Caldwell: Our descriptive data represent a good approximation of both general levels of function and the amount of variation that can be expected nationally and at every local site. Though not a major focus in our study, the health of young children has been of interest, especially in relation to whether the children had extensive Early Childhood experience. Our data are limited to respiratory problems, intestinal problems, ear infections, measures of growth, and an overall estimate of health of the child. Information about the incidence of these problems and general health was obtained by a maternal interview at three-month intervals throughout the first year of life. The growth data—height and weight measures—were taken during the laboratory visits. Looking at respiratory problems, the runny noses and the coughs that come with the territory of being a little child, the means and variability for the three groups are almost identical. Children in all three groups averaged about eight illnesses serious enough for the mothers to report. The poor group has a slightly lower median, but the spreads and the overall averages are very similar. Ear infection was an area of inquiry because of the possibility that middle ear infections can adversely influence language acquisition. On the basis of maternal report of ear infection serious enough to require medication, there are no differences in the means and ranges in the three groups. Because of the extreme importance of otitis media for language development, a substudy is underway in our project that uses actual medical records rather than maternal reports for estimates of duration and severity. In height and weight, the poor and near-poor children do not differ at all from the total sample. Most of the mothers in all groups considered their children to be in better than good health. Our sample does not reveal any major health deficiencies in two groups of economically distressed children. Our methods for collecting information in the health domain are adequate for descriptive purposes.

We will now look at cognitive and language development. As helping children acquire the skills needed to succeed academically in school has always been a major goal of Head Start, we examined the functioning of the children in the three groups on two measures of cognitive language performance, the Bracken Basic Concept Scale and the Raynell Language Scales. The Bracken is an age-normed measure of cognitive abilities that contains 11 subtests, of which we administered only five: colors, letter identification, numbers and counting, comparisons, and shapes. Each subtest was administered until the child either completed the entire test or failed three consecutive items. The scores on these five subtests were then summed to form a school readiness composite. The two low-income groups are almost identical, both in central tendency and range. The mean for the total sample is slightly higher and the range is greater. However, it is encouraging to note that pulling the low-income groups out does not produce a very different configuration. Children in the total sample fall within the same range as children in the poor and

the near-poor groups at age three. The Raynell is a language battery that can be used with children from one month to seven years. It has two main components: receptive language and expressive language. It was administered individually to the children when they came to the laboratory at 36 months. In conversational settings, children in the poorest group are likely to be somewhat less competent in understanding language used. In comparable data for the expressive language subscale, there is an almost identical picture. The only truly divergent group is the under-one income-to-needs ratio. In that sample, however, the variability is as great as it is in the total sample. Thus, again, our data show that summaries based on means or medians only, ignoring variabilities, do not tell the entire picture. The fact that incoming children can be expected to show considerable variability in their language functioning has clear implications for Head Start classroom practices.

To look at socioemotional functioning, we are reporting on data from the Child Behavior Checklist (CBCL), often called the Achenbach, and the Adaptive Social Behavior Inventory. Both of these instruments assess the child's repertoire or absence of social skills and patterns of emotional expression. In our study, if the children were in child care, we had the questionnaire filled out by both the mother and the primary child care provider. The data I am presenting are only from the maternal report. Within the CBCL, there are six descriptive categories covering a wide range of behavioral challenge. We have combined two of these—"Anxious, depressive and withdrawn"—into an internalizing subscale, and two—"Aggressive and destructive behavior"—into the externalizing subscale. Our data suggest that differences among the groups are not impressive. Poor children are often thought of, described, and reacted to as though they were, without exception, uncontrolled and excessively aggressive. This data does not support that mythology. Although both groups of children with income-to-needs ratios under 1.8 are described by their mothers as exhibiting a few more instances of externalizing, that is, aggressive behavior than characterized the total sample, the magnitude of the differences is not significant. Furthermore, variability is similar in all groups. Head Start teachers can expect a few more children acting out than teachers in other settings, but they can also expect to have plenty of children with good behavior control. There is an almost identical pattern for the internalizing behaviors. Teachers worry more about the externalizing behaviors, but clinicians consider the internalizing behaviors far more likely to indicate incipient psychopathology. The differences are very slight and would be of minimal importance in curriculum planning. However, teachers need to be oriented to somehow helping to compensate for the large number of mothers showing depressive symptoms.

The Adaptive Social Behavior Inventory (ASBI) items mostly describe prosocial skills. The ASBI has 30 items with two categories—"Express and Comply," which are prosocial behaviors, and "Disrupt," which are negative behaviors. As we look at the "Disrupt," the means are almost identical for the three groups. The median in the total sample is lower, as are the ranges. The range is identical for all three groups, as is their characteristic spread. There are slightly lower maternal reports of compliant and positively expressive behavior in the poor group, but similar ranges and spreads in all three groups. This last finding is especially worthy of comment, in view of the popular mythology that poor children are inordinately "difficult to control." There are some who contend that because poor children are accustomed to strict discipline, one cannot expect cooperation from them in the more permissive Head Start environment. Our findings would suggest that any entrance difference in this domain is slight, and that teachers need not anticipate trouble in securing compliance from all the children who will enroll in their programs. One of the main conclusions from this analysis is that these data should be seen as encouraging and reassuring about the characteristics and competencies of children as they enter Head Start.

Early Education, Child Care, and School Readiness

In this analysis we have looked only at family backgrounds, early child care history, and a few selected outcomes. Thus far we have not examined interactions among these variables, something that will be done in the future. What we found were some impressive differences in family patterns and child care histories in our groups and surprisingly few dramatic differences in child characteristics in terms of health, cognitive behavior, and socioemotional behavior.

Shannon Tanaka: San Diego County has the second-largest child population of California's 58 counties. The North County area residents served by Head Start are predominantly poor, ethnically diverse, and tend to be renters. They have less education than the general population of the county. Our service area consists of urban, suburban, and rural areas from the coastal area of Oceanside to the semi-arid mountains of Rincon and Valley Center. MAAC Project Head Start is an agency that serves 681 children and families. We have a total of 12 centers, 2 of which provide all-day care. One center runs for the program year and one is year round. This provides all-day care for a total of 36 children. We also have our year-round family child care program, with four providers in our most needed areas of Oceanside and Vista. We provide services in this program for 21 children. We also have a home-based program vital to our rural areas, where our teachers go to homes once a week to work with the parent and the child for an hour and one-half.

Child care issues continue to be an ongoing concern. The quality of care that is available to low-income families is highly uneven, as is the continuity of that care. Our families are often forced to rely on fragile and fragmented child care arrangements because of financial constraints. Much of the care received is custodial in nature and neither helps nor harms those they service. Our family sketch looks something like this: the parent of the child tends to be a single female, Latino, between 20 and 24 years old, in the workforce, or returning to school. The child is between three and five years old and tends to come from a fragmented caregiver setting, mostly among extended family members. Upon entry into the Head Start program, the child may appear to be more self-reliant and independent and have somewhat better verbal skills. He/she may also appear to be less trusting of adults to meet their needs, and to crave consistency. This child may also sometimes be more verbally or physically aggressive. If the child has younger siblings, the parent may rely heavily on the child to take care of those siblings. The child may exhibit and act out the stresses of the parent. Fragmented and fragile child care arrangements for a child prior to his or her entry into a Head Start program have definite implications for that program, and even more important implications for the child. Programs must be designed and staff must be developed to provide appropriate responsive quality care for the child, as well as a support system for the parent. Efforts to expand Head Start for infants and toddlers is strongly supported by MAAC Project Head Start.

Joan Lombardi: I continually try to raise the policy issues that people are facing because these data, particularly the low-income substudy, are going to be important. I do have some concerns about the use of father care as child care. I believe that father care is family care. We should be trying to distinguish between out-of-home care and father care. I also have a few words of caution about generalizing this data to the overall Head Start population. There were no teenage mothers in this sample, and that is a big difference. We have seen that Head Start families have become younger. Data on AFDC mothers show that one third to one half of poor mothers have high levels of maternal depression. That has enormous implications for Early Head Start and child care programs and linkages with mental health and Head Start programs. Though the range in a classroom of Head Start children is just like any other class in this data set, I do think more

Early Education, Child Care, and School Readiness

Head Start teachers are seeing more aggressive children, mainly due to media and community violence. We need to look at the children whose mothers have high levels of depression, and find out what is different in those families. Coupling the study of maternal depression with the JOBS evaluations would be important. Looking at Fulton County, the first in-depth child outcome study of the JOBS evaluation, found children not ready for school. There is something different in these two samples and we need to look at that.

Audience Questions and Comments

Comment: I am distressed to see how large the differences are in the language and cognitive development at 36 months. These are youngsters who have had only about 18 months to two years of experience with language, and already you are showing what looked like significant differences between the groups. Second, I am concerned about the level of externalization symptoms you are showing. I would take a bit of exception to what you said about the psychological interpretation of the dangers represented by externalizing versus internalizing behaviors. If you take a 30-year perspective, externalizing behaviors, especially as early as three years, are of much more concern to clinicians than are internalizing behaviors. I would strongly encourage you to look especially at the long-term data analyses that have been done by Shep Kellam, combining the evidence on externalizing and internalizing. Those youngsters who are showing both extreme externalizing behaviors and extreme internalizing behaviors show more evidence of drug dependence, more evidence of smoking, and more evidence of extreme psychological maladjustment as adolescents and young adults. In general, I would say the fact that you have this much externalizing behavior as a function of low-income as early as 36 months is bad news.

Betty Caldwell: There certainly were more indications, as you say, in the externalizing. However, on the whole they were all fairly low. One of the things that I hope we can do is to look at the ratings made by their child caregivers. We probably will have ratings on 100 in the poor group and about 75 or so in the near-poor group. My comment about clinicians considering their withdrawn, depressive behaviors more serious is perhaps dated with the concern with violence now.

Question: I am wondering if rates of growth in language and cognitive development and aggressive behaviors are different between the two groups.

Betty Caldwell: It has not been done yet. It takes roughly a year to get the data cleaned so that analyses can be done. One of the problems with young children is that you have different measures at different ages. On the family variables, we are more likely to have data that would make trajectories possible. We repeat the depression inventory several times, and we could certainly look at whether the mothers are depressed at the beginning, at 15 months, at 24 months, and so on.

Frances Campbell: If I understood what you did, you compared the lowest 30% to everybody. If you had compared them to the other 70%, would you have seen a different result?

Betty Caldwell: We would have seen a different picture.

Early Education, Child Care, and School Readiness

Question: Did you look at it both ways?

Betty Caldwell: No, not yet. There was not consensus among the members of the task force that the data should be presented in this way. The rationale for doing it this way was simply that we were not going to do statistical tests on this. We were going to look at the distributions so people would see where a particular group lies within the total distribution.

Comment: It obscures the problem a little bit. On the one hand, you are not singling anybody out, you are not pointing a finger, but what you are also doing is making yourself feel a little better. You are underplaying the problem.

Betty Caldwell: That is an important point. We will certainly take that back to the Steering Committee. Quite a few of us feel that way. In my presentation, I am the one who minimized the problems. The differences are much greater in the families, assuming that we looked at it in the right way, by keeping these distributions within the larger distribution. The differences in the early histories are certainly greater than the differences in the developmental measures that we have. The reason that in my presentation I stress the fact that these children are not as far behind as we had thought is that it strikes me that the challenge is for Head Start not to let them fall back anymore. They are not as far behind as when we first started Head Start. We do not at this point know whether the fact that they are not lower than they are is due to the fact that some of them are in very good programs with good families. Head Start has got to keep the children from dropping back.

■ The Impact of Professional Development Experiences on Quality in Child Care

Chair: Ellen Galinsky

Discussants: Betty Cassidy, Gwen Morgan

Presenters: Ellen Galinsky, Susan Kontos, Carollee Howes

As Head Start becomes increasingly involved with the provision of full-day services as well as community child care collaborations, it is important to assess the knowledge to date on child care quality and how it can be improved. The lack of quality in child care is well known. The focus of this symposium is on two studies that addressed the question: How effective are efforts designed to improve quality in early childhood settings?

The first of these studies, The Family Child Care Training Study, took place in three communities with Family-to-Family training programs for family child care providers under the auspices of Child Care Aware. Before and after Family-to-Family training, 130 providers in the three sites were observed and comparisons were made with 112 regulated providers in the same community who did not take part in the training program.

The Family Child Care Training Study found the following: 1) after training, children are observed to behave in ways that indicate they feel more securely attached to their providers; they become more engaged in activities and spend less time wandering about aimlessly; 2) global quality improved in the two sites that had lower overall quality scores before training; 3) after training, 97 percent of providers report their income from child care on their tax forms, up from 70 percent; 4) providers increase their commitment to their jobs and seek out additional opportunities for training, including Child and Adult Care Food Program training, family child care association workshops, and general courses in child development, and 5) providers increase their involvement in the Child and Adult Care Food Program, family child care associations, and the family child care community.

The Florida Child Care Quality Improvement Study was conducted by the Families and Work Institute to investigate how Florida's improved ratios (for infants from 1:6 to 1:4 and for toddlers from 1:8 to 1:6) and education requirements (at least one staff person for every 20 children with a Child Development Associate Credential or a comparable CDA Equivalency) affect the quality of early education and care and children's development. The sample consisted of approximately 150 licensed child care programs in four counties.

In assessing the impact of these changes, The Florida Child Care Quality Improvement Study found: 1) children engage in more complex play with objects and with each other, and they are observed to be more securely attached to their teachers, more proficient with language and have few behavior problems; 2) teachers are more sensitive and responsive; 3) teachers are less likely to respond to a child's misbehavior by yelling, scolding, threatening, being sarcastic, smacking, or hitting; and 4) global quality improved significantly from 1992-1994; between 36 and 42 percent of the children in this Florida study are now in growth-enhancing early childhood arrangements.

The Florida Child Care Quality Improvement Study *Ellen Galinsky*

The Florida Child Care Quality Improvement Study is being conducted by the Families and Work Institute to investigate how Florida's new ratios and education requirements affect the quality of early education and care and children's development. Data for this Interim Report comes exclusively from The Children Study, one of three substudies of this research project.

Early Education, Child Care, and School Readiness

The sample studies consist of approximately 150 licensed child care programs in four counties in Florida: Pinellas, Duval, Broward, and Hillsborough. These counties were chosen by the study's Florida Advisory Board because they are representative of child care climates within the State.

State legislation in Florida became effective in 1992, changing teacher-to-child ratios for infants from 1:6 to 1:4, and for toddlers from 1:8 to 1:6. In addition, effective in 1995, Florida requires that every child care facility have at least one staff person for every 20 children with a Child Development Associate (CDA) Credential, a comparable CDA Equivalency, and experience exemption, or a formal education requirement that is equal to or greater than the CDA Credential or CDA Equivalency.

This quality improvement effort was initiated by the state of Florida but has used federal money from the Child Care and Development Block Grant quality "set aside" to help implement these changes. This money is used, for example, to help establish CDA and CDA Equivalent training as well as to provide scholarships so the teaching staff of centers can enroll in these programs.

In assessing the impact of these changes, the Florida Child Care Quality Improvement Study found that:

- 1) Children's intellectual and emotional development improved. The list of changes in children's development is extremely impressive. Children engage in more complex play with objects and with each other. They are observed to be more securely attached to their teachers, which means they feel more safe and secure to explore, play, and learn. Children are also found to be more proficient with language and have fewer behavior problems. Overall, these changes are very important because they indicate that changing early education and care environments where children spend long hours day after day is linked to more positive development.
- 2) Teachers became more sensitive and responsive. This is significant because in order to prosper and learn in early childhood settings, children need teachers who care for and about them. They also need teachers who are tuned into them and respond in ways that capitalize on "teachable moments," such as bringing out a book about fire engines for the child who was captivated by a passing fire engine on the way to preschool.
- 3) Teachers' negative management styles declined.
- 3) Teachers are less likely to respond to a child's misbehavior by yelling, scolding, threatening, being sarcastic, smacking, or hitting. In some programs, this behavior was reduced by 75 percent.
- 4) Global quality improved significantly from 1992-1994. Between 36 and 42 percent of the children in this Florida study are now in growth-enhancing early childhood arrangements. This is an impressive accomplishment, considering that other community-based studies have found only 12 to 14 percent of the children in child care are in arrangements that promote their growth and learning.

The lessons being learned in Florida have tremendous implication for improving early childhood care and education across the United States.

The Family Child Care Training Study *Susan Kontos*

The Family Child Care Training Study is one of the first in a series of studies being conducted by Families and Work Institute that addresses the question: How effective are efforts designed to improve quality in early childhood settings?

The study took place in San Fernando Valley, California; Dallas, Texas; and Charlotte, North Carolina—three communities with Family-to-Family training programs for family child care providers. These training programs operated under the auspices of Child Care Aware, a national project operating in 40 communities, funded and sponsored by the Dayton Hudson Foundation, Mervyn's, Target Stores, Dayton's, Hudson's, and Marshall Field's. Since 1988, when Child Care Aware was launched, over 13,000 family child care providers have been trained.

Child Care Aware has four components: training, promoting accreditation, supporting the development of strong family child care associations, and consumer education to help parents learn how to find good quality child care. This study focuses on training. We chose to study the impact of the training offered by Child Care Aware sites because it exemplifies solid local customized training for family child care providers with great potential for wide-scale replication with either public or private funds. Before and after Family-to-Family training, 130 providers in the three sites were observed. Comparisons were also made with 112 regulated providers in the same communities who did not take part in Family-to-Family training.

The most important finding of the Family Child Care Training Study is that Family-to-Family training works. This is evidenced by the following:

- 1) Children are observed after training to behave in ways that indicate they feel more securely attached to their providers. They become more engaged in activities and spend less time wandering about aimlessly. Feeling safe and secure with their providers frees children to explore, play, and learn about themselves and their world.
- 2) Global quality improved in the two sites that had lower overall quality scores before training. Given the fact that according to participating family child care trainers, providers only received a short amount of training—between 18 and 36 hours—the finding that global quality showed improvement is impressive. This should not, however, be interpreted to mean that this is all the training that providers need.

In addition:

- 1) Ninety-seven percent of providers report their income from child care on their tax forms after training, up from 70 percent. This has great implications for the tax base in the United States.
- 2) Providers increase their commitment to their jobs and seek out additional opportunities for training, including Child and Adult Care Food Program Training, family child care association workshops, and general courses in child development. These data confirm the value that providers place on their training experiences and their willingness to devote time to them.
- 3) Providers increase their involvement in the Child and Adult Care Food program, family child care associations, and the family child care community.

The goal of Family-to-Family was to improve the quality of family child care. The results of this study indicate that this training is a very positive step toward that goal.

Early Education, Child Care, and School Readiness

Child Development Associate Credentials, Quality, and Children's Development *Carolllee Howes*

Paper summary not available

■ Emerging Narrative Abilities among Low-Income Children: Influence of Practices in the Home, Intervention, and Relationship to Social Competence

Chair: Margaret S. Benson

Discussants: Cornelia Greaves Shafer, Margaret S. Benson

Presenters: Susan Sonnenschein, Melissa M. Brown, Andrea Zevenbergen

This symposium on emerging narrative among low-income children was put together for two reasons. First, narrative is a basic way humans think about, organize, and relate events to one another, so understanding the development of narrative skills in children is a part of understanding their cognitive development, because most research on narrative ability has used middle-class children, it is useful to expand our understanding of normal development by looking at children who are not represented by a middle-class sample. Two, narrative is a way of talking about events that are not part of the here and now, the immediate context—what is called decontextualized language. Research has shown that a child's decontextualized language skills at entrance to kindergarten are a strong predictor of success in school past third grade. Therefore, understanding how children's narrative abilities are developing may help us better prepare them for school success.

The papers in this symposium look at a variety of narratives and the different experiences, both at home and at school, that support narrative. The first paper looks at informal, personal narratives; the second looks at mother-child interactions during shared book-reading, and the last looks at the influence of an intervention on more formal storytelling skills. All the papers relate narrative to dimensions of school behavior. All have implications for practice.

Personal Narrative and Its Relation to Other Aspects of Literacy Development

Susan Sonnenschein, Diane Schmidt, Beverly Pringle, Linda Baker, Deborah Scher

This paper considers some data from the Early Childhood Project, an ongoing longitudinal study exploring how children from different sociocultural groups experience literacy as they make the transition from prekindergarten through the early elementary school years. Of central concern is how the complex overlapping contexts of home and school interact to facilitate or impede reading development. The five-year, longitudinal study uses a combination of qualitative and quantitative measures. The children in the study come from low- or middle-income, African-American or Caucasian families.

Our focus in this paper is on children's personal narratives. More specifically, we consider the nature of prekindergarten and kindergarten children's personal narratives and any sociocultural and developmental differences in such narratives. We also relate these personal narratives to aspects of children's literacy-related development, more specifically their understanding of stories.

During both the spring of prekindergarten and kindergarten, children were asked to relate stories to an unfamiliar adult interviewer about some personal experience of interest to them. Narratives were scored for informativeness, ambiguity, digressions, temporal ordering, entertainment, and evaluation (making explicit one's viewpoint). During kindergarten and first grade, they were read stories and asked questions about these stories.

Our findings show that although there is a clear need for additional development, our prekindergarten and kindergarten children produced adequate narratives that more or less followed a story structure, were entertaining, and indicated the speaker's viewpoint. Children were weakest in injecting their point of view into narratives.

Early Education, Child Care, and School Readiness

There were also several sociocultural differences. Low-income prekindergartners included more uninterpretable or ambiguous information in their utterances than did middle-income prekindergartners. These differences disappeared by the time the children entered kindergarten. In prekindergarten, low-income children were more likely to inject their point of view into stories than were their middle-income peers. Again, these differences disappeared by kindergarten. Somewhat surprisingly, low-income children decreased the temporal or logical ordering of their narratives from prekindergarten to kindergarten.

Narrative production skills were relevant for aspects of later listening comprehension. The entertainment and evaluation dimensions in prekindergarten predicted aspects of subsequent listening comprehension. Informativeness in kindergarten was a significant predictor of listening comprehension as well.

Teachers of preschoolers should encourage children to relate and discuss their experiences. Our data also suggest that teachers, in giving feedback for narratives, should broaden their focus on what is important in a narrative. Encouraging children to insert their viewpoints and providing an interesting or entertaining tale seem relevant for later aspects of reading comprehension.

Mother-Child Interaction during Shared Bookreading and Social Competence at Head Start

Melissa M. Brown, Margaret S. Benson

Ed Zigler, a founding father of Head Start, contends that Head Start improves children's educational outcomes by improving social competence. Research from the consortium of longitudinal studies indicates that compensatory preschool programs such as Head Start facilitate children's social competency development through their beneficial effects on parenting. This study examined the relationship between mothers' interaction with their children during a wordless bookreading task and children's social competence at Head Start. It was predicted that children of mothers who scaffolded the task well (i.e., who asked questions about feelings, who restructured questions with more information, who elaborated on responses, and who ignored off-target comments) would demonstrate social competence at Head Start. It was also predicted that poor maternal scaffolding (providing answers, prodding the children by repeating questions and correcting the children's responses) would be associated with social competency deficits.

There were 39 three- to four-year-old Head Start children and their mothers participating in the study. The participants were given the wordless picture book *One Frog Too Many* by Mercer and Marianne Mayer and asked to make a story together. Videotapes of these interactions were transcribed verbatim. As well as the types of interactions previously enumerated, the number of maternal talk turns and the proportion of adequate child responses were tabulated. Social competence was assessed via teacher ratings, sociometric reciprocal friendships, and the amount of time children were observed in social play.

Variance due to frequency of maternal interactions and child competence during the bookreading task were controlled for with the use of partial correlations between maternal interactive behavior and children's social competence. These analyses revealed the following: children's classroom friendships were predicted by mothers asking about characters' feeling states, elaborating upon their children's contributions to the story, and ignoring children's off-target comments and questions. Alternatively, children who had relatively few friends had mothers who prodded them for answers by repeating questions, who restructured questions by asking them in different ways, and who tended to answer their own questions. Children who were observed in relatively high rates of social play had mothers who elaborated their responses and who refrained from prodding or restructuring their questions. Teacher ratings of social skills were predicted by

low rates of maternal prodding during bookreading, and a tendency for the mother to answer her own questions during the bookreading.

Clearly, maternal interaction patterns during this bookreading task were related to children's social competence at Head Start. Although the correlational design precludes drawing conclusions about causality, the possibility remains that children learn the basic structure for their interactions with peers from their mothers and how they interact together during shared bookreading.

Effects of an Interactive Reading Program on the Narrative Skills of Children in Head Start

Andrea Zevenbergen, Grace Wilson

Many children from socioeconomically disadvantaged families enter kindergarten with significant delays in their narrative skills. The purpose of this present study was to determine if children in Head Start could make gains in narrative abilities as a result of participation in an interactive reading program. In Whitehurst's dialogic reading program, the child is encouraged to be an active participant in reading stories with an adult. It was hypothesized that children who participated in a dialogic reading program while in Head Start would demonstrate gains in narrative development over the course of the Head Start year that were greater than those of children who did not participate in the reading program.

Children's narrative development was assessed at the beginning and at the end of the Head Start year by having children participate in a story-retelling task called the Bus Story. Children's narratives were scored for inclusion of story elements (e.g., complicating events, story resolutions), use of connectives (e.g., "because," "although"), use of evaluative devices (e.g., dialogue, statements regarding characters' emotions) and decontextualization.

The study sample consisted of 124 four-year-old children. Thirty-two percent of the sample was Caucasian, 39 percent of the sample was African American, 28 percent of the sample was Latino, and one percent of the sample was Asian. The subjects were enrolled in 16 classrooms in four Head Start centers on Long Island, New York. Classrooms of children were randomly assigned to intervention and control conditions. The intervention was a year-long dialogic reading program; in the control condition, the children participated in the regular Head Start curriculum.

Subjects' Bus Story narratives at pretest and posttest were coded for the following 10 variables: total number of story elements included within the narrative, decontextualization, use of connectives "but," "so," "because," and "when," and four types of evaluative devices, namely, use of dialogue, use of words pertaining to characters' emotions or thoughts, asking "wh-" questions of the adult, and using words describing causality.

Given the large number of variables, principal components factor analyses were conducted on the 10 narrative measures that were obtained for each child at pretest and posttest. Two factors, Narrative Content and Language Complexity, were extracted from the pretest and posttest measures. Separate ANCOVA analyses were conducted for each of the posttest factors. ANCOVA revealed a significant effect of the dialogic reading intervention upon the Narrative Content factor ($p < .04$). Thus, the children who participated in the dialogic reading program produced narratives at the end of the Head Start year that were significantly better in terms of content than those produced by the children who did not participate in the reading program. The second ANCOVA, examining the effect of the intervention upon the Language Complexity posttest factor revealed no significant difference between groups on this factor. These results provide further evidence of

Early Education, Child Care, and School Readiness

the effectiveness of dialogic reading techniques in facilitating Head Start children's development of language and emergent literacy skills.

Comments from First Discussant: Margaret S. Benson

The thing that stands out about all these papers is that they are about success; they are about the skills that children are demonstrating, and about the things parents are doing that promote those skills. Thus, they remind us of the basic normalcy of the children we serve in Head Start.

Sonnenschein and her colleagues' paper is important because personal narrative is something that we all do. Linking skill at personal narrative with school skills is important because 1) it indicates that something as simple as talking about daily events with your young child will help prepare her/him for school; and 2) it implies that all the different narrative genres, and the different social situations in which they occur, contribute to the skills needed for early literacy.

Research has repeatedly shown that one family practice, reading to children, is highly correlated with future school success. The regularity with which middle-class children are read to has been documented, and research finds that among the social classes, low-income families are least likely to read to their children. As the studies in this symposium report, researchers today are attempting to look at how children are read to, and what it is about that experience that promotes emerging literacy.

Melissa Brown's contribution suggests that the way a parent and child converse over a book helps the child learn conversational skills and discourse practices as well as enhances her/his skill of reading to other people, all of which contribute not just to literacy skills, but to the repertoire of social skills. The practical implications of this are far reaching, and lead me to point out the importance of research to replicate these findings and extend them so that the possibility of training mothers in shared bookreading might serve as an intervention to promote better mother-child relations.

Andrea Zevenbergen is sharing with us a piece of a larger set of data on an intervention study. Her work is important as it attests to the generalizability of the skills learned by children who were part of the intervention. More importantly, it suggests that this intervention influences the development of decontextualized language skills—those skills that are important for school success beyond the primary grades.

Both of these studies indicate that there is much to be gained from promoting bookreading or other materials among low-income families. I hope that Head Start practitioners will go back and work with families on this activity.

Sonnenschein remarked that she had visited classrooms in which children were not encouraged to relate personal experiences. I, too, have visited classrooms in which teachers do not chat with children. I have also visited classrooms in which children are not read to daily. I want every Head Start practitioner here today to vow two things: 1) help teachers see the value in the time they spend talking with children about everyday events; and 2) see to it that every child is read to every day.

Early Education, Child Care, and School Readiness

Comments from Second Discussant: Cornelia Greaves Shafer

We are living in a decade in which people want answers to their questions and pay-offs on their investments. As a director of a Head Start program for 10 years, I feel myself challenged now as never before. The community at large is challenging me to demonstrate that 1) what we do is worth the investment; and 2) what we do results in positive, long-term outcomes. Head Start families are increasingly stressed and oppressed by their situations; Head Start staff are facing increasing numbers of highly disruptive children and are less confident about their approaches. Shrinking resources demand that I work with my colleagues to assure that we are putting our limited resources to maximum use. As I read the papers, I came to see them as a pivotal point for the challenges that face me.

The heart of intervention strategies or best practices gleaned from these papers is an extension of sensitive and responsive parenting. It involves hearing where the child is now, responding effectively and assisting the child to move forward. It is a process of looking at available resources, discussing the perspectives of each partner on those resources, and determining what should be done with them.

These strategies strike a resonant chord with much of what is being read in the board rooms of corporate America. "Learning organizations," "flattened organizations," and organizations committed to total quality management all rely on a rich pattern of interaction in which all players assess the environment, plan, and respond strategically.

What we need is someone to connect the dots between the practices presented in these studies and the long-range outcome of a creative, energetic work force. Perhaps a partnership with the corporate world to underwrite and publish articles in the business world would make that connection. These approaches can also inform our work inside the programs, both in terms of training for those who work directly with children (staff and parents), and in terms of organizational structure and culture.

In all Head Start families and programs, and elementary schools working with Head Start children, the challenge is to assist caregivers to become comfortable with an interactive style of "teaching." To do so requires more than one yearly training session. We need to develop and utilize multiple approaches for providing training to staff and parents that will assist in making them comfortable with this process. And we need to provide ongoing support and coaching to assist staff to meet their expectations.

The intent and, to a large extent, the gift of Head Start for the past 30 years has been an organizational culture that utilizes dialogue as a springboard to decision-making. But we must continue to be a model for learning organizations.

One of Head Start's great legacies is our initial goal—to assist children to develop social competence. But we have not organized ourselves to demonstrate the extent to which we do that. The efforts of researchers could help inform those at the Department of Health and Human Services who continue to search for measures of meaningful outcomes for programs such as Head Start.

Techniques to Facilitate Children's Development of Narrative Skills in the Classroom

Grace Wilson, Andrea Zevenbergen, and Margaret Benson

Below are some techniques that can be used to facilitate children's development of narrative skills, as well as their overall language skills. Many of these ideas are based on the personal experience of Grace Wilson, who teaches with the Head Start program in Suffolk County, NY.

Early Education, Child Care, and School Readiness

1. Give the child opportunities to retell stories from picture books to adults or peers. This can be done by an adult with an individual child, or with pairs or small groups of children retelling the story to each other. Right after reading a story to them, the teacher may ask children to take turns telling parts of the story, or ask questions aimed at helping them understand the sequence of actions or the motives of characters. If the teacher has used a flannel board in telling the story, the children can manipulate the flannel board characters and objects as they recall the story. Flannel board objects and characters from well-known stories can be put out to let children retell stories to each other.
2. Dramatizing stories provides an opportunity for children to learn the structure of stories and practice a variety of narrative skills. Acting out a story has the advantage of involving the child's whole body, thus using all the senses. Although this activity is typically done during circle time, it can be done with small groups and no audience.
3. Teachers may draw a series of pictures of the events in a story told by the child, focusing on creating pictures that capture sequence. The finished group of pictures can be used by the child to retell the story. Conversely, the child may draw a picture, or series of pictures, and tell the teacher the story that goes with the pictures. If the adult writes down the words, the child has a book that can be read again and again.
4. Sometimes it is useful to have an adult write down stories that children make up. Some children like to illustrate their stories after they see them in writing. Both this activity, and those described in item three, promote the understanding that the printed word represents spoken language.
5. Sequencing stories can be practiced with flannel boards. If children are given specially made sets of three or four pictures that depict a story, they can place the pictures in sequence and tell each other the story. This also helps children use conjunctives to connect the events in the stories they are telling. Give children pictures to use with the flannel board so they can invent their own stories.
6. Children may also develop narrative skills from singing songs that tell a story.
7. Narrative abilities are also developed by relating personal narratives. This can be done in one-on-one interactions with adults, in small groups (for instance, meal times), or at large-group time. A recent activity will be easier for a young child to recall with some detail than a distant one (for instance, asking children what they did from the time they woke up until they came to school).
8. When children share an event in school, making a record of it on a story board (i.e., with drawings or photos), helps them recall that event, and share it with one another. When put into an album, these items become a record of the year the class was together, and a source of many personal narratives. In choosing activities to facilitate narrative development, it is important to select activities that children can relate to (familiar characters or activities) that are developmentally appropriate.

■ Longitudinal Research with High-Risk Families

Chair: Alice Honig

Discussants: Sheldon White, Marilyn Thomas

Presenters: Alice S. Honig, Christine Morin, Arthur J. Reynolds, Sherri Oden, Lawrence Schweinhart, Byron Egeland

Long-term follow-up of children at high risk for developmental difficulties is more likely than an immediate postintervention assessment to clarify how accurate predications are with respect to which children and families may need and will profit most from early intervention services. Decisions to pinpoint the length of service or the type of services that are most efficacious, such as whether to enhance parenting skills or provide early educational enrichment programs, or both, can be made more accurately if long-term rather than short-term developmental outcomes and program benefits are assessed. Longitudinal studies help confirm the validity of measures by which programs assess early risk and assign or reject families for program supports. They highlight the differential importance of risk factors in early development, such as social economic factors versus interpersonal temperamental factors. Prospective longitudinal studies can better clarify theoretical arguments about the relative importance of developmental discontinuity or continuity (whether homotypic or heterotypic) in describing the trajectory of outcomes. Continuity of program effects may well depend significantly on maintenance of supports for high risk families. Differential attrition rates among control and served groups in longitudinal follow-up studies reveal how difficult it may be to confirm program effectiveness over time, despite excellence in early intervention models or programs. The four projects examined in this symposium illuminate some of the issues noted above through the presentation of longitudinal follow-up data.

Continuity of development in low- and high-risk samples was examined by Dr. Egeland and E. Adam, who report that low risk and a stable environment are significantly related to continuity of developmental adaptation from infancy (where attachment had been assessed) to the early school years (where peer competence and emotional health were assessed). High-risk children showed far less continuity.

Dr. Honig and C. Morin's research reveals that a home visitation program for high-risk teen mothers served to decrease the probability of later confirmed child abuse neglect when teens remained in the program for two years rather than dropped out after a few visits. Significantly more protection against later occurrence of abuse was shown if program participation began prior to the infant's birth. Program cost effectiveness was demonstrated.

Drs. Oden, Schweinhart, and Weikart, and Y. Xie examined the long-term benefits of Head Start Planned Variation Model versus regular Head Start two decades later at sites in Florida and Colorado in contrast to a no-Head Start group that was established. After adjusting for background differences since the original Head Start subjects came from more economically impoverished family backgrounds, educational and life outcomes were generally equal to or somewhat better for the original Head Start subjects than for no-Head Start subjects, particularly for females at one site.

Dr. Reynolds' study of the Chicago Child-Parent Centers (CPC) indicates that the effect of one or two years of CPC preschool program participation was consistently significant from kindergarten to grade six for reading and math achievement, grade retention incidence, and special education placement. The positive impact of CPC occurred partly because the program promotes cognitive development and parental school involvement in economically disadvantaged families.

BEST COPY AVAILABLE

Family Support and Parenting

In this symposium, discussants Dr. Sheldon White and Marilyn Thomas emphasized the importance of long-term follow-up data in assessing program effectiveness for disadvantaged families and their young children.

Longitudinal Evaluation of a Teen Parents and Babies Program *Alice S. Honig, Christine Morin*

This longitudinal follow-up study explored the potential effectiveness of an outreach home visitation program for low-income teen mothers in reducing confirmed child abuse/neglect, as well as the effectiveness of program delivery begun prior to, rather than after, the birth of the baby.

The Teen Parents and Babies Program (TPBP) provides weekly home-based parenting education by early childhood professionals along with modeling of developmentally appropriate physical and cognitive stimulation and promotion of affectionate mother-infant interactions. Potential participants are referred to TPBP from local agencies. Only applicants assessed as having high stress and low resources, and therefore at high risk for future child abuse, are eligible for the program. Teen mothers were between the ages of 13 and 21 ($M = 17.55$), and 95 percent receive public assistance.

Three groups of mothers were identified: 1) Non-Program Contrast low-income teen parents ($n = 90$) judged not at high risk for child abuse/neglect and not admitted into TPBP; 2) Program Graduates ($n = 81$) initially judged at high risk for child abuse/neglect, who participated in the program for 18-27 months (mean number of home visits = 58.9, $SD = 26.8$); 3) Dropout Controls ($n = 39$), judged as high-risk parents admitted into the program but who chose to drop out shortly thereafter ($M = 6.9$ home visits, $SD = 4$). Intervention subjects were further divided as a function of time of program intake, whether prebirth or postbirth. Confirmed child abuse/neglect data were obtained, two to six years after initial contact, from the county Department of Social Services files for 204 of the original identified 210 families.

Mean abuse rates for the Non-Program Contrast Group, Program Graduates, and Dropout Controls were 16.7, 15.6, and 40.5 percent respectively [$F(1,114) = 9.15$, $p = .003$]. Scheffé post hoc tests confirmed that Program Graduates had a significantly lower abuse rate than Dropout Controls ($p < .05$), but not a significantly different rate from the low-risk Non-Program Contrast Group. Dropout Controls had a significantly higher abuse rate than the Non-Program Contrast Group. Thus, ongoing participation in the TPBP program was successful in decreasing confirmed abuse rates several years after program termination.

ANOVA comparisons of abuse rates between prebirth and postbirth admissions to TPBP revealed significant differences of time of intake [$F(3,110) = 5.1$, $p = .0009$]. By Scheffé post hoc tests, Prebirth Graduates (7/52) had a significantly lower abuse rate than Postbirth Dropouts (13/24) ($p < .05$ by Duncan post hoc test), but they did not have significantly lower rates than Prebirth Dropouts (2/13). Postbirth Graduates (5/25) did not differ from Prebirth Graduates; they had a significantly lower confirmed abuse rate than Postbirth Dropouts (13/24), but they did not have lower rates than Prebirth Dropouts (2/13). Thus, initiation of home visits prior to infant birth made a significant difference in preventing later child abuse/neglect, even for teen mothers who later dropped out of program.

A significant difference in parity rates between the Program Dropouts ($M = 2.14$ children) and the Contrast Group ($M = 1.68$) was found, but no difference was found between Program Graduates and the Contrast Group. No difference in birth spacing was found among these groups.

Mean program cost for home visitation was \$3.83 per family per day. Foster care cost in the county for confirmed child abuse/neglect cases is \$23.75 per day per child. Thus, the TPBP program proved highly cost effective.

Preschool Participation and Scholastic Adjustment: Findings from the Chicago Longitudinal Study *Arthur J. Reynolds*

The Child-Parent Centers and Expansion (CPC) Program in the Chicago Public Schools is the second-oldest federally funded preschool intervention program in the United States. Established in 1967 and funded through the U. S. Department of Education, the centers provide services annually to about 5,300 economically disadvantaged children and families. The program emphasizes comprehensive educational and family support services from ages three to nine. The preschool and kindergarten program includes half-day preschool (ages three and four) and half- or full-day kindergarten in 24 sites. The expansion program provides extended intervention services for two or three years (grades one to three) in the parent elementary schools and is designed to support continuing scholastic and social development.

The Chicago Longitudinal Study (CLS) traces the school success of 1,539 low-income children (95% African American, 5% Latino) who were kindergarten graduates of the Child-Parent Centers in 1986 and completed their eighth-grade year in 1994. This representative sample of children also includes a comparison group of kindergartners in six schools that did not participate in the CPCs but who did participate in an all-day kindergarten for at-risk children. The CLS is the most extensive investigation ever of the CPCs. Yearly data have been collected from school records, teachers, parents, and students. Study findings, based on analyses of 1,164 children who were active in the Chicago Public Schools in eighth grade (spring 1994), indicate the following:

1) Preschool participation was significantly associated with higher reading and math achievement test scores in eighth grade (above and beyond other factors). Preschool participants, on average, scored five months higher in reading and in math achievement in eighth grade on the Iowa Tests of Basic Skills. They also were significantly more likely than their comparison counterparts to pass a life-skills competency test, which is required for high school graduation. Moreover, the parents of preschool participants were more likely than the parents of no-preschool participants to participate in school activities (in grades one to six). Children who participated in preschool also were less likely to repeat a grade and receive special education services. Twenty-four percent of preschool participants were retained in grade during elementary school compared to 32 percent of no-preschool participants, a 25 percent reduction. Preschool participants, on average, spent four fewer months in special education than no-preschool participants during elementary school (five months versus nine months).

2) Duration of program participation (zero to six years) was significantly associated with higher reading and math achievement test scores and with lower rates of grade retention and special education placement (above and beyond background factors). For example, children who participated for five or six years 1) scored about one year higher in reading achievement than children who did not participate; 2) had a 63 percent lower rate of grade retention; and 3) spent, on average, five fewer months in special education during elementary school. Duration of program participation also was significantly associated with greater parent involvement in school and with less school-reported

Family Support and Parenting

delinquency behavior. Notably, both preschool and school-age components of the program contributed to longer term school success.

3) How do the longer term effects of the program come about? Children who participate in the program are more likely to enter kindergarten ready to learn. In addition, the program encourages parent involvement in school and in children's education such that when the intervention ends, parents are more likely to continue their involvement. Avoiding grade retention and frequent school mobility also helps to maintain learning gains.

Study findings are especially noteworthy because most studies of the long-term effects of early intervention come from small-scale programs that differ in significant ways from Head Start and other government-funded programs. Many studies have methodological problems (e.g., attrition) that have been avoided in this study. Thus, large-scale programs that provide comprehensive educational and family support services can improve children's later scholastic competence and behavior.

The Long-Term Benefits of Head Start Study: Implications for Research and Practice

Sherri Oden, Yu Xie, Lawrence Schweinhart, David Weikart

The Long-Term Benefits of Head Start Study originates from the Head Start Planned Variation Study (HSPV) of the early 1970s. A long-term, follow-up study of the original HSPV Model Program versus Regular Head Start subjects was conducted in northwest Florida and northern Colorado, where the Model Program subjects made intelligence test score gains in elementary school (Marshall, 1973). A no-Head Start comparison group was added to the follow-up study, using original school enrollment lists, addresses, and U.S. Census poverty tract data. Of the identified potential study subjects, 71 percent of the Colorado pool and 80 percent of the Florida pool were located and interviewed at 22 years of age, resulting in 290 former Head Start subjects and 332 former no-Head Start subjects, who were from African-American, Latino, and White ethnic backgrounds. The data sources include the interview data, U. S. Census tract-level data, and data from school records, criminal records, public assistance, and a functional literacy test. Although the Head Start and no-Head Start subjects were from the same or nearby neighborhoods, the analyses showed that the Head Start subjects were from more economically impoverished family backgrounds: more single parent households, more children, lower educational levels of fathers, and lower overall socioeconomic status. Thus, Head Start staff had accomplished what they were required to do—to effectively recruit from the most economically impoverished families.

To estimate Head Start's long-term effects, Sue Marcus and Yu Xie used different statistical approaches to control for the original family background and neighborhood differences, including selection modeling, propensity score matching, odds ratio analyses, and others. After adjusting for the background differences, to the degree possible with the available data sources, the educational and other life outcomes of the Head Start subjects were found to be generally equal to or better than what they would have been without Head Start. In one site, Head Start females achieved higher educational levels than did no-Head Start females. Further support of Head Start long-term benefits was indicated by more positive life outcomes for Head Start model program subjects from the original HSPV study. Although this study employed a quasi-experimental design and retrospective family background measures, several specific findings coincide with

those obtained in other studies (e.g., High Scope Perry Preschool Study, Schweinhart et al., 1993; the Early Training Project, Gray, Ramsey, and Klaus, 1982). In conclusion, based on the study data, the investigators predict that if future studies of Head Start were to utilize random assignment to groups, or more effectively control for potential family and site background group differences, the studies would likely find 1) positive long-term benefits from Head Start participation into adulthood—in higher grade-point averages, high school completion rates, and post-secondary education participation, and fewer criminal arrests and convictions; and 2) positive benefits from model programs such as High Scope or other model child developmental approaches. The further challenge, as researchers, is to identify program and contextual features that will enable practitioners to reliably replicate long-term benefits.

Continuity of Development in a High-Risk Sample *Byron Egeland, Emma Adam*

Most investigators would agree that there is considerable continuity between childhood and adolescence and adolescence and adulthood. Although change has been noted, Block and others studying normal development have found continuity across this period. In the burgeoning field of developmental psychopathology, investigators have demonstrated continuity, especially between childhood externalizing problems and problems in adulthood.

Continuity between infancy and later adaptation is less well established. Some reasons for inconsistent findings during this period may be due to questionable assessment procedures. Using comprehensive assessments of adaptation, we and others have found a relationship between adaptation in infancy and later developmental adaptation. Our measures of developmental adaptation were designed to assess the salient developmental issues of a particular period. For example, during infancy we used the Strange Situation to assess attachment relationship, and at age two, toddlers and mothers were observed in a problem-solving situation designed to assess quality of adaptation at this developmental period. At preschool and in the early school years, comprehensive measures of adaptation assessed the salient developmental issues of these periods. Although this strategy involved changing assessment procedures at each developmental period, we have found a fairly high degree of continuity from infancy to the early school years. However, we found less continuity in our high-risk sample than Matas found in the middle-class sample using the same measures of adaptation. We hypothesize that the greater the risk status of the sample, the less continuity there is between attachment in infancy and later adaptation.

To test this hypothesis, we determined the risk status of each mother-child pair in our longitudinal study for the period from 30 to 64 months. Risk factors were low SES (unemployed); above-mean standing on cumulative stressful life events; single parenthood; maternal depression; below high school education at birth; and physical abuse of mother. For the total sample the mean number of risk factors was 2.26. Individuals with two or fewer risk factors were considered the low-risk group, and those with scores of at least three were in the high-risk group. The outcome measures were teachers' rankings of emotional health/self-esteem and peer competence, and the social withdrawal scale from the Child Behavior Checklist TRF in grades one, two, and three.

Two (Secure vs. Insecure) $\times$ two (high- vs. low-risk) ANOVAs were conducted separately by sex. A number of main effects were found for both risk and attachment; however, no risk $\times$ attachment interactions were found. Despite the failure to find significant interactions, the results for boys were quite consistent with our hypothesis of greater continuity for low-risk subjects. For low-risk boys, significant differences favoring those securely attached at 12 months were found on peer competence in grades one and three and emotional health in grade two. There were no

Family Support and Parenting

significant differences within the high-risk group of boys, although peer competence in grades two and three approached significance. For low-risk girls, the only significant difference was found on social withdrawal in grade one (insecure were more withdrawn); and there were no differences within the high-risk girls. Clearly, low risk and stable environmental influences are related to continuity of developmental adaptation across infancy to the early school years, especially for boys.

■ Enhancing Resiliency through Family/Community Interventions with High-Risk Children: Current Canadian Models

Chair: Gerard M. Kysela

Discussant: Ray DeVere Peters

Presenters: Linda McDonald, Jane Alexander, Jane Drummond, Deborah Breakenridge, Liz McDougall

This symposium examines the effect of family and community intervention in natural settings on family support, self sufficiency, and children at high risk for future difficulties. Participants, including the comparison group, were enrolled in urban Head Start centers. Two interventions were examined in a cross-over design. Both single-subject outcome and group outcome data were analyzed to determine the impact of family interventions. All phases of this research involved collaboration between researchers and practitioners.

Interventions fostering protective factors with families of at-risk children enhance both the children's and families' resiliency against future risks. The goal was to develop and test a program of home support designed to enhance family resiliency and increase development of social, cognitive, and communicative competencies of children. Developmental difficulties included significant child communication and the intellectual and/or behavioral problems necessary for successful participation in school and community.

The project focused on developing more effective cognitive skills, parent-child interpersonal relationships, friendships, social competencies, adequate self-control, and emotional expression. The study involved two interventions: the Cooperative Family Learning Intervention and the Natural Teaching Strategies Intervention, developed in collaboration between the researchers and practitioners from local Head Start programs. Interventions were provided in the home and community in addition to family involvement in local Head Start programs. These family-level interventions resulted in greater resiliency for both the child and family. The discussant compared the Better Beginnings Intervention Model with the Family Focused Model, both conceptually and empirically.

Family Functioning and Interaction: How Does It Enhance Child Resiliency?

Linda McDonald, Jane Alexander, Gerard Kysela

Cooperative Family Learning: How Does It Enhance Family Resiliency?

Jane Drummond, Linda McDonald, Jane Alexander

Family-Level Interventions and Resiliency: The Role of Field Agencies in Planning Research and Dissemination of Results

Deborah Breakenridge, Liz McDougall

The development of child and family resiliency in the face of adversity is recognized as being crucial to successful family functioning. Threats to family functioning originate from socioeconomic factors, child needs, and family behaviors. Researchers have developed models of family functioning to help practitioners identify key issues and critical times for families. One such model, the Resiliency Model of Adjustment and Adaptation, was designed to capture this complex system of interactions. Kysela, McDonald, and Alexander in a previous project examined this model's use in explaining family adaptation to demands and hassles in raising a child with special needs. Their findings suggested that families continually adapt to demands instead of encountering crisis situations that force adaptation. A new model, the Family Functioning Model, has been developed. It characterizes the ways in which families meet the demands placed upon them. It has found that family supports and global optimistic parental appraisals mediated the

Family Support and Parenting

stress of parenting children's special needs. A path model and LISREL analysis were used to test these mediating variables.

Mangham and colleagues summarized the findings concerning family protective and risk factors in resiliency. Family protective factors included positive parent-child attachment/interactions, quality parenting, household structure and rules, family coping and hardiness, father involvement in child care, positive expectations for the child's future, mother's education, detachment from troubled background, supportive spouse/partner, maternal employment, and a positive marital relationship. Individual attributes such as self-esteem and intelligence also function as protective factors. Finally, environmental influences such as involvement in the community contribute to resiliency in families. They concluded that resilience at the family level could, theoretically, be conceived of as an interplay of social, cultural, environmental, and emotional aspects of coping.

In the light of the research evidence supportive of enhancing resiliency, the research team at the University of Alberta developed a series of three manuals for early interventionists that cover areas of family functioning, including assessment of family strengths and needs and two specific types of intervention, Natural Teaching Strategies Intervention and Family Cooperative Learning Intervention.

In this presentation, the latest in a series of studies by this research team will be discussed. The study involves children in three ABC Head Start programs in an urban setting. In the study, the family-centered approach to intervention was examined together with the impact of both of the aforementioned interventions. Specifically, the following hypotheses were tested: 1) Head Start positively affects general development and social competence for children in the comparison group, but children in the intervention group will exhibit greater advances in several domains related to enhanced resiliency; 2) the Natural Teaching Strategies Intervention affects specific protective factors for resiliency in children and families (child's social competence, interpersonal skills, communication competencies, and cognitive competencies; families' child-parent attachment/interactions, household structure and rules, and positive child-parent communication); 3) Family Cooperative Learning Intervention affects specific protective factors for families and children (families' effective parenting practices, good coping strategies, effective cooperation strategies, enhanced parental self-esteem, and stronger support networks; child's positive self-esteem, mastery behaviors, and good effective problem-solving skills).

The results of the first six months of the study were presented; data analysis provides differential outcomes for the intervention/comparison groups, as well as repeated measures of the intervention group child and family variables for the single-subject design contrasts. The data has been assessed using the Family Adaptation Model as a conceptual framework to identify the supportive effects on resiliency of the two types of interventions.

Comments from Discussant: Ray DeVere Peters

Combining Community Development and Child Development Approaches to Prevention: The Better Beginnings, Better Futures Project

The Better Beginnings, Better Futures Project is a 25-year longitudinal prevention research project being carried out in eight socioeconomically disadvantaged urban and native communities in the Canadian province of Ontario. Project goals are 1) to prevent serious social, behavioral, and emotional problems in young children; 2) to promote the healthy development of these children; and 3) to enhance the ability of families and communities to provide for their children. The

project focuses on over 4,000 children from birth to eight years, their families, and their neighborhoods. Communities are funded by the Ontario and Canadian governments to develop and implement high-quality prevention and promotion programs for young children and their families. Programs are to be characterized by integration of services for children and families, and by meaningful, significant involvement of community residents in all aspects of program development and implementation (i.e., community development is viewed as an important vehicle for fostering human development).

All sites are implementing a range of prevention program components: child-focused (e.g., child care and classroom enrichment, play groups, breakfast programs); family/parent-focused (e.g., home visiting, parent training, parent support groups); and community-focused (e.g., improving neighborhood safety, antiracism workshops, community celebrations, native culture, and community healing programs).

The research component of the Better Beginnings, Better Futures Project addresses three general questions: 1) are the community programs effective (outcome research); 2) are the programs affordable (economic analysis); and 3) what structures and processes are associated with program results (process research)?

Family Support and Parenting

■ A Head Start for Families Experiencing Homelessness

Chair: Colleen E. Morisset

Discussant: Lenore Rubin

Presenters: Colleen E. Morisset, Mary Seaton, Carmen Rivera

Since its inception, Head Start has been concerned with children in poverty. Severe poverty leaves many families homeless. Children whose families are homeless not only suffer the stresses associated with economic hardship, but also experience little continuity and predictability in their young lives. Their "homes" are transient and opportunities for learning and forming long-term relationships are few. In addition, compared with low-income families who are not homeless, parent-child relationships are compromised by homeless parents' emotional unavailability due to overriding concerns such as adequate food and a clean, safe place to sleep.

This symposium describes a Demonstration Project designed to offset identified risks to children who experience homelessness. The service model is complex. At its core is the use of Head Start Family Child Care.

The strengths of the Family Child Care model overcome many of the obstacles to learning and self-sufficiency typically encountered by families who are homeless. First and foremost, the family child care sites provide a sense of "home" for homeless children and their families. Family child care homes are intimate settings with a single caregiver nurturing a small number of children of mixed ages. High adult-to-child ratios, combined with full-day hours of operation, make it easier for providers to spend daily individual time with each child. In addition to frequent one-to-one interactions, the provider's respected position and knowledge of the community help homeless families gain a sense of stability, safety, and belonging.

Second, all providers meet the same educational and skills training requirements as Head Start Center-based teachers. This means that program children, as well as other non-Head Start children in their care, benefit from high-quality care.

Third, because family child care providers' expertise extends downward to children younger than the four year olds typically enrolled in Head Start center-based programs, preschool children and their younger siblings can stay together during the day. What is more, they can be joined by their older siblings in the after-school hours. This benefit of family-based care can bolster homeless children's rather tenuous sense of safety, identity, stability, and "family."

Finally, the family child care home plays the role of a temporary, physical "home." When possible, children's health and social services are provided on site for easier and more immediate access. Because children don't have to be shuttled from one service to another, or from one place to the next, several times a day, children can dare to form connections and feel a part of something. Parents can use this time to make connections too—the types of connections and changes that will benefit their families. The bonus is they can do this knowing their children are safe and well cared for. This psychological and physical "freedom" creates an opportunity to make the most of what service providers and case managers can offer to facilitate adult and parenting-skill development.

Family Child Care Relationships: Helping Homeless Families Succeed Colleen E. Morisset

In 1994, the Head Start Bureau awarded the Puget Sound Educational Service District funds to improve and extend Head Start Services to homeless families. The goal was to extend Head Start services, using the Family Child Care model, to additional families residing in an area of the service region with the lowest per capita income and most rapidly increasing population. A

second goal was to improve services to the homeless children already being served in existing Head Start programs. This was accomplished through staff training in the special needs of homeless children and families and, as necessary, the provision of the specialized individual and family services (e.g., mental health services) to all homeless Head Start families.

New families are recruited by the staff of three transitional housing facilities in South King County. Children are transported by bus from these temporary housing sites to the participating family child care homes in three shifts to accommodate parents' varying schedules. Depending on parents' work and school schedules, children can spend as many as nine hours a day in family child care, five days a week, but most spend five to eight hours a day, three to five days per week.

Between June 1994 and March 1996 (the cut-off date for this analysis), 41 children representing 36 different families, enrolled in this program. As of March 1996, mothers' average age was 23 years; ages ranged from 16 to 41 years. Most mothers (61%) had not completed high school. The racial and ethnic groups that comprised the largest segment of the sample were: Caucasian (36%), Latina (28%), and African American (22%). The majority of mothers were unmarried (97%) and receiving government assistance (97%).

Study children were on average 24 months old; the age range was 2 to 58 months. Less than one half the children scored within the normal limits on the Denver II, a widely used developmental screening tool. The most common area of concern was language development. Twenty of 31 children evinced problems or delays in language. The next most common area of concern was personal and social skills.

As of March 1996, twenty-eight children received at least one month of child care; approximately one half received 1 to 4 months of care, and approximately one half received 6 to 12 months of child care.

Program evaluation centers around two primary objectives: to promote healthy child development and to promote healthy family functioning through the provision of an appropriate range of services for homeless children and families. The subset of program families for whom follow-up data are currently available show many important gains: 1) between enrollment and beginning child care, most children were brought up to date in terms of physical and dental health; 2) between enrollment and exit (or one year's time), mothers reported a significant decrement in stress due to parental distress; 3) 75 percent of mothers reported fewer family needs; 4) 92 percent of mothers achieved two or more of three personal goals; and 5) 50 percent of children showed fewer delays and cautions on the Denver II.

Linking Head Start and Family Goals: The Importance of Flexibility *Mary Seaton*

The Puget Sound Educational Service District (PSESD) Head Start Homeless Services Project is funded by a three-year Demonstration Grant to develop full-day, year-round Head Start services for children ages birth to five living in transitional housing. Enrolled children are cared for by licensed family child care providers who have contracted with PSESD Head Start to offer comprehensive developmental and educational experiences while parents attend work, training, or educational programs. Parents must maintain active participation in their assigned program to stay in transitional housing. All enrolled families utilize state and county child care subsidies to pay for the necessary provider fees while Head Start funds are used in three ways: to provide transportation services; to enhance, train, and monitor family child care sites; and to coordinate collaborative family service and health planning and delivery.

Family Support and Parenting

In addition to full-day, family child care, children enrolled in this program receive physical and developmental screening, the WIC nutrition program, and social, health, developmental, and mental health services. Parents also participate in parenting groups that blend Head-Start-eligible and other parents whose children attend the same child care setting. This provides a much needed community-building experience. When parents receive these services at a site located in their community, they build ties that will empower them to become active citizens with the ability to access needed resources.

A unique feature of Head Start Homeless Services is how it coordinates and facilitates interagency efforts to make the most of staff energy and resources of the agencies involved. This feature keeps costs for our comprehensive services down while allowing us to focus resources on individualizing services to families' needs, and making them accessible and appropriate. Coordinating our efforts also provides parents with a wider, more cohesive support network with which to share necessary information and concerns. Parents may feel more trust or have more immediate access to their child's care provider, the Homeless Services Program Coordinator, Housing Site Case Manager, or even our staff bus driver.

At the core of this project is the effort to help families build relationships and connections that are critical for their future success. For children, the family child care model provides connections and relationships with a single caregiver in a small group setting. For parents, the child care providers work to build partnerships that address concerns for children as they arise and support parents' efforts to move forward. For families, the strong relationship between the Head Start program and the housing sponsor assures that expectations required of parents are compatible and mutually enhancing rather than pulling families apart.

Puget Sound Educational Service district and our community partners—YWCA, Kent Youth and Family Services, South King County Multi-Service Center, and King County Child Care Program—are working together to continue this important resource for families, even beyond the Demonstration Project funding period.

Staying the Course: One Parent's Story *Carmen Rivera*

When Carmen began the Homeless Services Program, she had recently fled an abusive husband. She had her four children and barely more than the clothes on their backs. "I was so depressed. I was grieving for the relationship I had lost, and I felt like a failure. I missed my job but couldn't think about getting a job right away. I contacted my former supervisor, who was happy to recommend me to the Washington State office of the same company, but when I went to the building, I could not walk in. Somehow it was all connected to the failure and my abusive relationship."

"The opportunity to enroll my two youngest children in Head Start came during my stay at the transitional shelter. At first, I couldn't decide if it was really going to be any benefit to me or not. Maria (the provider) comforted me and explained what the program could mean to me. She took a lot of time with me and shared information about development, and she also talked to me about what I was going through. Maria also helped me with books and articles about children the same age as mine. The Homeless Services coordinator helped me get my oldest son enrolled in special services through the public schools. He now attends part-day and is at Maria's the other part of the day."

"Every time I was feeling like it was too much, someone in the program would encourage me. You (Homeless Services coordinator) called once when my child care subsidy was denied.

and I still remember the feeling that someone out there cared. I started volunteering at the child care center and learned even more. I asked for a mental health observation of my oldest son who was clingy and often had bouts of anger. We now receive in-home services once a week from a counselor and I am learning a lot. The parent meetings have been great. At first I did not want to attend, but I found I was not the only parent that had problems raising kids."

"When I first started this program, my youngest child just laid in his playpen with his blanket and bottle. I was so depressed, I didn't care. If he was quiet and didn't need anything, I didn't bother to interact with him. He didn't laugh or talk hardly at all. I didn't know how my depression was affecting him. Now, since I have been involved in Head Start, I know what my child's needs are. Now Anthony laughs and plays and is very active. My friend remarked how she couldn't believe the difference in him. He is different because I realized that he needed more interaction than I was giving him. He is now a happy child."

Carmen has now completed training and is employed as our staff bus driver. In addition, she has moved to a safer place with her children. She has plans to go to school and take math so that she can "help her children with their homework." She adds, "I also want to study mechanics."

Comments from Discussant: Lenore Rubin

Families often reach homelessness by one of two paths. Some are suffering from the effects of long-term generational poverty, while others face more acute crises such as domestic violence. Depending on the route, families might have differing needs; either way, they have special needs requiring tangible services like housing and transportation. Programs serving children in transition must be family centered and assure parents that their children are safe and well cared for. Furthermore, such programs must respect the parents' wishes for their children.

The nontraditional Head Start model described in this presentation meets the needs of homeless families in many ways. For instance, it provides transportation and full-time, year-round child care. In addition, it supports families in the process of becoming stabilized by requiring fewer transitions, including the identification of just one primary caretaker relationship with the family. This increases feelings of safety and control for everybody. The provision of on-site services further allows parents to utilize services they might otherwise reject. Mental health services, often difficult to access, are accepted when offered on site. Often these families have limited capacity for dealing simultaneously with the myriad issues that affect their well-being. This model increases their capacity for addressing the issues affecting their stability.

The frequency of child and family assessments also makes sense since these children can make rapid gains as their situations improve. These gains need to be recognized and goals reformulated. This reassessment also teaches parents about the possibilities for growth and change, and can impart a sense of hopefulness to the family.

Provider training and the broadening of expertise is also important. Anticipating the "special needs" of this population helps providers enrich their programs for all children. The mix of ages and possibilities for individual attention increase opportunities for growth. Training also serves to "normalize" the behavior of children in transition. Providers learn about the consequences for children of parental stresses and the homeless experience, and do not overreact when presented with difficult behaviors.

Because these families are in relatively short-term housing, services must be delivered with optimum efficiency. This program is aware of the need for a prompt response and infusion of services. It also maximizes the possibility for forming stable relationships with community mem-

Family Support and Parenting

bers. Traditional center-based or school-based programs initially foster more of an "institutional transference," where the community is the school. In contrast, this program for homeless families encourages the formation of relationships with a community of families.

This program illustrates the importance of policies that allow for the development of creative and, most importantly, flexible options for addressing the needs of the underserved. I suspect this flexibility, in addition to other features of this program, could be successfully incorporated into programs serving other children and families facing a range of difficulties, including drug effects and long-term poverty.

Head Start has a positive reputation and a great measure of credibility in the community. It provides a terrific resource for families with preschoolers and should be maximized to serve all families well.

■ Family-Centered Home Visits: How Do We Know They Are Family-Centered?

Chair: Susan L. McBride

Discussant: Ann S. Bardwell

Presenters: Donna Bryant, Suzanne Gerlach-Downie, Susan L. McBride

There has been a recent increase in the provision of home-based early intervention services for young children and their families, and it is anticipated that this trend will continue. While the rationale for home visiting as an effective intervention is theoretically and anecdotally well supported, empirical evidence documenting the treatment effects of home visiting for children and their families is both limited and varied. Studies to date have focused on the relative efficacy of home visiting compared to center-based services, but few attempts have been made to describe what occurs during home visits or investigate underlying change processes set in motion by home-based intervention. Gray and Wanderson warned that the assumption of homogenous treatment in home visits is unjustified; however, little research has been conducted to investigate the focus or intensity of home intervention processes. The three studies presented in this symposium have initiated efforts to document the process of home visits in a variety of home visit programs with both quantitative and qualitative methodologies.

The first paper reported findings from a survey of home visitors and focus groups with parents who were receiving home visits from a variety of programs. Findings included challenges of home visiting and personal skills and necessary job support reported by home visitors. Parents attending focus groups discussed their concerns about home visitation and the trusting relationship necessary for developing effective provider-parent relationships.

The second paper was a qualitative study of home visits with Latino and Anglo families conducted for the Parents as Teachers program. Focus groups and interviews with family members and parent educators revealed that the Parent Educators emphasized the family priorities for the child, and minimal intervention was focused on adult issues.

The third paper documented the process and content of home visits with young children with disabilities using observational data. Findings revealed that the content of home visits is primarily focused on the child, with the majority of the home interventionist's time spent in direct teaching activities with the child. There is some evidence to support the individualization of home visits based on family resources and child caretaking demands.

Dr. Ann S. Bardwell, Director of the Drake University Head Start Program, was the discussant for the three papers. She raised a number of issues based on the presentations and her years of experience with home-based early intervention programs. She stressed the importance of both program staff and research evaluation efforts to articulate both the child and family outcomes that they expect to occur as a result of the intervention. Related to this, she challenged us to determine the rationale for the selection of home-based intervention and the conceptual basis for the focus of intervention. Dr. Bardwell argued that staff training must be tailored to the goals and objectives of the program to assure the integrity and fidelity of the intervention. Only then will we know how our research and evaluation efforts are to be interpreted. These remarks stimulated extensive audience participation and discussion of issues.

Family Support and Parenting

On Being a Home Visitor and a Home Visitee: The Perspective from Visitors and Parents

Donna Bryant, Donna Scandlin

Evaluations of home visiting programs show mixed results in terms of child and family outcomes, yet home visiting programs seem to be increasing in number. In 1995, in a midsized North Carolina city, at least 32 different programs used home visiting as one, or the only, method of reaching parents of young children. We have been working with these programs to promote coordination. This presentation summarized some of the findings and themes that emerged from home visitor surveys among this group and focus groups with parents participating in the programs. Forty home visitors responded to the survey. All were female, with 82.5 percent White, 15 percent African American, and 2.5 percent biracial. Their mean years on the current job was 5.5, with an average of 6.6 years of experience as home visitors. The majority (55%) had Bachelor of Arts (B.A.) degrees, and 37.5 percent had Masters degrees, mainly in education and social work.

Survey questions concerned 1) why people became home visitors (i.e., an equal number because they want to help and support others or because it was part of the job description); 2) the biggest challenges of home visiting (i.e., safety, building trust, finding people at home, and working with multiproblem families); 3) the personal skills that are helpful to home visitors (i.e., communication and listening skills, being open-minded); 4) the kinds of job support desired (i.e., working with a supportive team and good supervision); 5) topics of interest (i.e., working with and motivating hard-to-reach parents, adolescent parents, and substance abusers); and 6) how programs might be improved (i.e., reducing paperwork, and using computers and cellular phones).

Five focus groups of parents were held with audiotapes transcribed and reviewed for themes about the process of home visiting and what it was like to be home visited. Parents who attended these discussions were very positive about the programs and their visitors, and preferred receiving services in the home. Specific fears about home visiting were 1) worry about their messy house; 2) embarrassment over their children's actual or potential misbehavior; and 3) concern that the visitor would see something that might provide grounds to remove the child(ren) from the home. The trust they developed in their home visitor was essentially what helped parents overcome these fears and worries.

The results lead to at least four implications. One, good communication is the most important element of successful home visiting. Establishing effective helping relationships requires empathy, respect, and genuineness. Two, programs must be more clear about their goals, mission, and content. Three, it appears that it may be helpful, and in some cases necessary, for home visitors to suggest or promote some goals, at least in the early stages of home visiting. Finally, because the emotional support to the parent seems the most appreciated and memorable part of a home visiting experience, measurement of the effectiveness of home visiting needs to include the kinds of socioemotional outcomes that might result from such positive experiences.

Where is the Family in a Child-Centered PAT Program? An Analysis of One PAT Site

Suzanne Gerlach-Downie, Kathleen Hebbeler, Marcela Lopez

The presenter of this paper summarized preliminary results of a evaluation of the Parents as Teachers (PAT) program in Salinas, CA. The study reported is part of a large evaluation of the PAT program conducted by SRI International. The researchers in this smaller study used qualitative methods and focused on data analyses on data from 1) case studies of 21 families in the PAT program, including videotapes of home visits, interviews with the families, and interviews with the appropriate Parent Educators (PEs); and 2) focus groups with 10 PEs.

According to its developers, PAT is intended to serve as a preventative program to inform parents of children ages birth to three about good parenting practices and principles of child development. The PAT program uses home visits as the centerpiece of its prevention/intervention strategy. The home visits typically begin soon after the birth of a child and continue until the child's third birthday.

Traditionally, home visiting programs have been categorized into two categories: parent education and family support. Stated simply, the parent education philosophy emphasizes that parents have a lot to learn about child development, and the parenting and family support philosophy emphasizes that parents need support, encouragement, and validation. PAT developed out of the parent education framework, but has adopted many of the assumptions of the family support framework.

The question of interest to the audience of this symposium was the extent to which the PAT program reflects or is compatible with family-centered practices. The definition of family-centered practices used in this paper is from Odom and McLean and is concerned about the welfare of the family and the welfare of the child rather than focusing exclusively on the child. The family (inclusive of the child) becomes the center of the intervention decision and efforts. The intervention program is peripheral to the family, facilitating the family's objectives and priorities for the child.

The question of interest was explored in terms of the structure of the home visit, the content of the home visit, the nature of the interaction between the PEs and the parent, and the nature of the relationship that developed between the PE and the parent.

The data indicate that the level of intervention the PEs provided to the parent about adult issues, such as employment, was minimal. On the other hand, the program clearly put an emphasis on "facilitating the family's objectives and priorities for the child" in other respects. For example, the PEs supported the parents' (and other family members') expertise about their children and encouraged different perspectives to be heard and understood.

Parental empowerment was a stated goal of the PEs. The PEs in this PAT program believed that more active involvement on their part in solving family problems would diminish, not enhance, the parents' ability to meet their goals for their children in the long run by undermining their sense of parental competence and responsibility. The extent to which this holds true for different parents is worthy of further investigation.

Home-Based Early Intervention with Families of Children with Disabilities: Who Is Doing What? *Susan L. McBride, Carla A. Peterson*

The purpose of this study was to document and describe the content addressed and the processes employed during home visits conducted by early childhood special educators with children birth to three years of age and their families where home visiting has been the primary service delivery mechanism for early intervention services. A second objective was to investigate whether the content and process of home visits vary based on characteristics of families or their children.

Fifteen home interventionists, 28 families, and 28 children, each of whom had a disability, participated in the study. The Home Visit Observation Form (HVOF) was developed to document the content and process of home visits. The HVOF allows a nonparticipant observer to record information in four categories: 1) individuals present (simply identifies each participant by title); 2) primary interactors (identifies the participants interacting, as well as the individual directing

the interaction); 3) content of the interaction (identifies the topic of conversation during the interaction); and 4) nature of the home interventionist's interaction (describes the focus of the home interventionist during the interaction). Observational data were collected via the HVOF during six home visits (approximately one per month).

Mean percentages of time for each behavior category were calculated to describe home visits. Almost half of the time (46%), home interventionists were in joint interaction with the parent or another professional and the child. Twenty-six percent of the interactions involved home interventionists interacting with children; parents and home interventionists interacted with each other 21 percent of the time. Striking is the small amount of time that the parent interacted with their child without involvement of the home interventionist (3%). The focus of interactions during all home visits was clearly on the child's skill development or caretaking. Very little time was spent on family issues or discussing community services. During interactions, home interventionists spent the majority of their time in direct teaching activities with the child who had a disability. Another quarter of their time was spent providing information to parents or others or asking for information from them. Little time was spent listening, observing, or modeling for parents.

To assess how home visits differed in relationship to characteristics of children and families, observational data were further examined by dividing families into four demographic groups reflecting their resources and child caretaking demands. Independent sample t-tests revealed that home interventionists spent significantly more time on the child's skill development during home visits with families who had adequate resources ($M=91.4$) compared to families with limited resources ($M=85.4$), ($t=-2.44$, $p<.03$). Conversely, content of the home visit was more likely to address family issues when family resources were limited ($M=5.9$) compared to when family resources were adequate ($M=2.2$), ($t=1.96$, $p<.10$). When children had greater caretaking demands compared to those with fewer demands, home interventionists were more likely to participate in joint interactions (with parent or another adult) with the child ($M=3.00$ vs. $.22$), ($t=-2.67$, $p<.02$) or to observe others interacting with the child with a disability ($M=8.82$ vs. 5.38), ($t=-1.84$, $p<.10$).

■ Children in Out-of-Home Care

Chair: John Hagen

Discussant: Edith Fein

Presenters: Pat Dubus, Rosalind Folman, Ellen Pinderhughes

John Hagen: We are going to be looking at many different aspects of children in out-of-home care: the foster care system, children in foster care, and the later consequences as these children move into adulthood. I am struck by the fact that the risk and resiliency models that are so prevalent have important implications for the children in this population. The findings seem consistent that if children have one or two risk factors, they do very well. When you get up to about three and more risk factors, you are looking at children that seem to be vulnerable and show many difficulties. Almost by definition, most of the children that we are going to be talking about are probably in the three-or-more risk factor categories. Therefore, we are looking at a population where one would expect that there are going to be problems.

Rosalind Folman: I am going to give a quick overview of both the lives of foster children before they came into care, and while they are in care looking at their experiences through their eyes. The purpose is so that you can understand the context of their lives. Without the context, you cannot give meaning to their behaviors. Some of their behaviors are very deviant.

My presentation is based on a study that I have been conducting with John Hagen over the past four years where I interviewed 95 children in Detroit who were in foster care. All of them had been placed because of parental maltreatment. They were between the ages of 8 and 13, and they had entered care between the ages of 5 and 12.

First, I want to give you a look at what their external worlds were like. These were the shared norms that came out. Their survival strategies are deviant, making it difficult to tell them that they should not use violence, lying, or stealing, because that was how they lived before they came in. The other thing about it was their lack of awareness that their norms were deviant. One child was telling me about her mom, who was a good mom. She said that her mom taught her how to take care of herself. I asked what she taught her. She said that she taught her how to steal and fight. There was no awareness that this is wrong.

I asked the children if they could tell about any instance where their mother protected them. A little boy told me of a time a six-year-old boy next door hit him, and he told his mother. She went next door and beat up the six-year-old boy. What they learn has an odd coherence to it. It is as logical and coherent as society's so-called normative values and structure. In reality, they are missing the basic foundations of development, structure, and societal values. They learn how to get what they need and how to harm others, but little or nothing about how to do good for themselves or others.

What may be more critical is their early years. Bowlby proposed that children, through their ongoing interactions with their environment, develop internal working models of their attachment figures in themselves. These working models are used to interpret and guide the child in a new situation. The children with a secure attachment are in a much better position to cope with the stresses of foster care. Out of the 95 children that I interviewed, only about 6 or 7 had good early caretaking. These were children whose mothers were there for them the first few years and did not get into drugs until they were five years old, or did not meet the abusive boyfriend until they were four or five years old.

The majority of the children had insecure attachments. These children had not learned that adults cared about them or that adults can be trusted. In fact, they approach adults only when they

Family Support and Parenting

are not in distress. They enter foster care and Head Start seeing adults as uncaring and untrustworthy. Let me demonstrate how this plays out.

Here are two 13-year-old girls. One was my most resilient child. She had good early caretaking the first five years. The other one had no good memories at all. I asked them to describe a caseworker that they shared, an extraordinary caseworker who took them out for weekends to Canada or Chicago, who took them to sports events. I asked the first one, who had good early caretaking, about her relationship with her caseworker. She said that she could talk to her about anything. It was just like her mother's relationship. I asked her, "Do you think caseworkers care about children?" She said, "Oh yeah, mine does. She takes me places on her own time, and whenever we have a problem, she is there for us. You can tell we are all special to her." Same caseworker, description by the second child: "You can't trust them." I said, "Why can't you trust them?" She answered, "Cause they're going to tell what you said. They do what they want. They don't care about kids." I said, "She doesn't care? You told me she took you to Canada, to Chicago for weekends, to concerts." She said, "Yeah, she probably did it to get a raise or a promotion." I said, "Would you go to your caseworker if you had a problem?" She said, "No, I don't have no problems."

There are two things about the second quote. It is a very common answer to say, "I have no problems." The message was sent implicitly; it was not stated right out: The caseworker and foster parents do not want to hear the pain and the problems. It hurts too much to hear these children's stories. The message that is given is that we want to see happy children, so the children do not talk about their problems. The other thing I wanted to demonstrate with this quote is that she has never been valued; she has no view of herself as being valued. Even when the resources are there, this child cannot use them.

Unfortunately, this perception of adults as uncaring, and as people who cannot be trusted, is confirmed when they come into care. This is a summary of the day of placement. Of the 95 children interviewed, no one deviated from the story. Instead of receiving new experiences where they were valued and where they were comforted and cared for, they were taken by the police or by the caseworker out of their home. No explanation was given to them. They were put in the back of a car and taken to an agency where they were put in a room for 2 to 10 hours. No one came in except to bring donuts and ice cream; no one comforted them or provided information. It was usually siblings huddled together. Then the caseworker would put them in a car. If the siblings were to be separated, it was not until they pulled up to the first house that the person would say, "You—you will be living here." That is when they learned that the only family they had left would be taken from them. They were implicitly told that they were not valued and there was no one there for them. No one wanted to hear their pain. Without being told what would happen to them, the children filled in the gaps with their own thoughts. The distortions in their thoughts as to what would happen may be more idiosyncratic among preschoolers, since they are still at the age of magical thinking. Also, preschoolers still have cause and effect mixed up, and are more likely to see themselves as the cause of placement and of bad things happening to them. It has a greater impact on the younger child.

Since no one at the agency helped them, I asked them what the foster parent did on the first day. With the exception of three children, the rest said that the foster parent did not help them. What they reported was that they would come to the house and the foster parent would tell them to wash up for lunch or to take a bath before bed. These children have suffered the greatest loss imaginable. The adults around them behave as if nothing had happened. This lack of validation is still another part of the trauma for them. For the child, the experience is another denial of her

existence, rejection of who she is, confirmation that there are no adults to care for her, and finally it is experienced as another abandonment. The failure to validate their perceptions and feelings by saying, "I am taking you to a nice lady's house and everything will be okay," teaches the children that they cannot trust their own perceptions and their own feelings. They have learned this in their home. They heard their mom tell the caseworker that she does not do drugs, but they saw her doing them. They heard her say that she does not neglect them, and they know she has been gone for several weeks. This is especially detrimental to the preschooler who is just trying to learn the difference between fantasy and reality. To develop a sense of reality, the child needs to be in a truthful environment, one that is not contradictory. Here they are given just the opposite.

The lack of validation causes still other problems for the children's development. To maintain their placement, the children learn to operate in two realities: one that accepts the adult view that everything is okay, and the second, which the children keep hidden, that holds onto their perceptions. The long-term effect of this was demonstrated this summer. I was interviewing a 13-year-old child. I have never in my life seen a child in so much pain—filled with rage, pain, and sadness. I asked him what he was going to do with all this rage. I told him he could not keep it in. He said, "I have to keep it in because if I don't, I'll have to get a gun and start killing people." I went to his worker and told her this story, and she expressed surprise. She considered him to be happy.

Let us look at the foster care-related issues, tasks, and stresses that may impact the children's behaviors in the Head Start setting. In addition to the stresses that foster children share with other Head Starters, like poverty, poor health, and poor nutrition, they have extra stresses. It is the number of stresses that predict pathology; it is not the severity of the stressor. These children who are off the scales on a number of stresses are at extremely high risk. Here are some of the things that affect them in their everyday life once they come into care. Parental visits are distressing to the children: saying goodbye to their parents, parents not showing. They may not understand the court hearings. If they have older siblings in the home, they will pick up on the anxiety from these children. Replacement is a stressor for them, as is caseworker turnover. Besides these stresses, which are unique to foster care, the children also have tasks that they must master in order to settle into foster care. These are tasks in addition to their developmental tasks. For these children, it is hard to unlearn an old way and to learn new rules. Many of these children have never heard of rules before. They come from families with no structure.

There are other stresses that they face in care. I highlighted the first one, parental rejection and abandonment and a sense of worthlessness. The loyalty confluence is strong even for the younger children. These are children who live in one home and love in another. If they come in at two or three years old and are placed in Head Start at that point, even if they have no replacements, they go through the ongoing loss and change. The foster family is constantly changing. This stirs up loss over and over again. Given their enormous deprivation and high number of stresses, these children are so needy that they stress the capacities of any adult to the utmost. It is important that their needs and behaviors are understood by the people with whom they interact. Any kind of separation is going to stir up the original separation. There may be an absence of exploratory behaviors in these children because of the attachment problems. They might be clingy and more aware of where the adult is in the environment. Not being chosen for something, the sense of not belonging, is a big problem for the children. Birth children are treated differently, and they are treated more like an outsider. That stirs up problems.

Before getting to what Head Start can do, I want to mention things that helped the children on the day they came into care. It could be divided into three categories. One, give the children

Family Support and Parenting

control. One little boy told me what helped is the next day his foster mom told him he could choose whatever he wanted for breakfast. It is a small thing, but when you have no control in your life, it makes a big impact. Two, validation is the second grouping. These children are given no information about anything in their lives. Anything that you explain to them about the Head Start setting: why something happened, why they were not chosen, is important to them. The last thing was family connection. If in any way they can have pictures of their parent or siblings to help them deal with the separation, put the pictures in their little cubby, and when they are getting out of control, let them go see them.

I also identified some protective factors among the more resilient children. I will refer to two here. The most outstanding one was being a parentified child. By being a parentified child they had a sense of self-efficacy. Within a Head Start setting, if you can put them in charge of the guinea pig, another child, or some kind of chore, it gives them a reason or a purpose. It is important to them. The other thing is effective coping strategies. Many of the coping strategies were antisocial. Most of the resilient children had big mouths, but they protected themselves. They were rebellious and outspoken. We need to look at these behaviors within the context of their lives. This is the way they maintain their sense of self.

What can Head Start do to help these children? Assign the child any adult in the Head Start setting to whom the child feels close. Assign that adult to be the attachment figure for the child. The second important thing is the alliance with the foster parent. Unlike birth parents, who may be afraid to pry, a foster parent does not feel shame over the bad behavior of the child. So she is very willing to talk about her problems. She also needs the support, and she wants it. Many of them that I spoke to were not psychologically minded and did not understand the children's behavior. If Head Start would help them with that, it would give them the ability to empathize with the children, rather than respond to their behaviors.

In order for Head Start personnel to do these things; they need a few things. They need training that would sensitize them to the children's reality, to become aware of the things that I just listed. Most of them are not the usual run-of-the-mill things that happen in children's lives. They also need information about what is happening in the children's lives. These things affect the children's day-to-day behaviors in Head Start. Without knowing when these things are happening, there is no context for understanding the child's sudden aggression or sudden tantrums.

Ellen Pinderhughes: I am going to talk about readjustment in foster families and borrow from my work, which is heavily in the adoption area. In the last 13 years, we have seen a dramatic increase in the rate of children entering foster care. Unfortunately, in the last seven to eight years, we have seen a decline in the number of foster families available. One reason may be the complexity that these placements involve. Foster children come to a new placement with histories of abuse and neglect from biological families. They come into foster families on a temporary basis. Thus, foster families face the psychological task of parenting children from troubled families for uncertain periods of time. This complex reality makes understanding foster family functioning critical. However, research on foster care has focused on children's characteristics, their functioning, parent characteristics, and efforts at reunification and permanency. We need to understand more about those members of the foster family, not simply the foster child and foster parent, but also siblings, the diadic relationships between siblings and foster children, and the family system at large. Since the foster family is a critical context for foster children, understanding how these families function can enhance our effective service delivery.

Two critical areas include family readjustment to the entry of the child as well as the removal of the child from the placement. Although we know little about the transitions associated with foster placements, there is a developing literature in the area of older child adoptions that can shed light on these related processes. As with foster children, older adoptees enter new placements with histories of dysfunctional and often abusive parents. I will be presenting some research that I have been involved in that follows families who adopt older children. I will discuss some of the implications of readjustment among foster families. Underlying my work in this area is a theoretical model that posits individual diadic and family system readjustment. It is informed by literature on attachment, family systems theory, family stress and coping, and adjustment to transitions. Key domains of functioning that are important for us to understand include representations, what expectations family members have, their internal models of their own roles, and their relationships, as well as behaviors—problem behaviors and interactions at the diadic level and the family system level. Other relevant domains include available resources, both within and outside the family, and what stressors there may be, either placement related or that occur outside the placement but may affect the placement.

Awaiting adoption, family members develop expectations about what is to come, how relationships will be formed, how individuals will adjust, how the family system as a whole will change and come to function as a new system. We heard from Rosalind how children going into foster families have different expectations and concepts about what is appropriate behavior and appropriate caring. It is also hypothesized in the model that we can see some of this for children entering adoption. As a result, the family and the child may have different expectations about how the family is going to function. We can see that the stage may be set for some clashes at the interaction level, at the expectation level, and so forth. After placement, the family moves into accommodation, where individual role exploration and diadic boundary exploration and negotiation take place. What is key here is that family members test the fit of their expectations before placement with what is happening after placement. As they evaluate the fit of what is happening, they may be thrust into the next phase—resistance, which is characterized by ambivalence and by attributions about whether problems that occur are placement related or are related to the adoptee. Family members may find themselves having second thoughts and considering disruption, and at the family system level, the family may resist changing. In individual family members or in the diads, there may be some resistance to adjusting expectations or adjusting patterns of interaction to incorporate the adoptee. Although ambivalence is normative, how families deal with it may come to affect how they restabilize. In restabilization, families can function in one of three ways: 1) they can disrupt, with the adoptee returning to the foster system, experiencing yet another loss; 2) they can restabilize in what I call a dysfunctional incorporation, where they commit to the placement and legalize it, but the adoptee is the one expected to do all the changing; 3) they can restabilize in a healthy incorporation, where family members make compromises and sacrifices at the expectation and the behavior level to incorporate the adoptee. Some families may bypass resistance and move straight to restabilization from accommodation. Families who do this may either be families whose preplacement expectations fit what happens during the accommodation period so that they enter the placement with realistic expectations, or, upon the discovery that the expectations had been unrealistic, they are flexible enough to adjust their expectations to be constant with how the adoptee is functioning.

I am going to present some preliminary findings from an exploratory study that I have recently completed. It was a study following families from preplacement to eight months after placement. Here are highlights of what we found. First, one of the clear findings was a discrepan-

Family Support and Parenting

cy between the kinds of problems parents anticipated and the kinds of problems that they reported. When we asked what kinds of problems they anticipated, the highest percentage of problems fell into the parent/child relationship domain. Only nine percent of the problems that they anticipated were specifically behavioral. In contrast, behavior problems accounted for 42%. There is a wide discrepancy between what parents expect going into the placement about behavior problems and what parents actually report. There could be a number of explanations, including selective hearing on their part when the child was presented to them, selective presentation on the part of the worker, the fact that they did anticipate that the adoptee would change certain behaviors going in, and so, perhaps, they did not anticipate those would be problems.

I will now present patterns across the families related to their adjustment over the eight months. In multiple domains we saw a pattern of a decrease in functioning with some stabilizing and then some recovery by the eighth month. As the placement moved into the fourth month, there was a wide variation across the families. We also see that the stress declined over the following months after month four. That was pretty consistent. With some of the other measures, we do see the families decline by the third month. We see another kind of drop-off at six months. Then we see some improvement. Other behavioral measures also showed a similar pattern. Despite this pattern of decline and recovery, we saw for the first parents a somewhat stable, slightly declining, but, given the score, stable level of satisfaction. Parents tended to be fairly satisfied with the placement. It did not increase even though we saw recovery in some of their emotional connectedness and in some of their coping behaviors. One of the reasons we think that we did not see an increase in the satisfaction is that parents are still coming to terms with the reality of the problem behaviors with which they are contending.

The expectations forecast something. Here are two sample families where the expectations made a difference. One family had expectations of behavior problems and had prior child rearing experience. They showed decline, but they showed some recovery. There was a decline with the behavioral measure, but there was their report of the family cohesiveness, of family coping. We see some increase in the adoption satisfaction by the parent. In contrast, we see a couple who adopted a young adolescent. This couple did not expect behavioral problems which, unfortunately, was very costly for that placement. The behavioral measure of affective status shows a decline and does not show recovery. The cohesion and adaptability shows decline. Satisfaction plummets. Stress on the part of the parent also increased dramatically. This family disrupted six months into the placement.

Our findings suggest that there is a pattern of readjustment with a period of decline in functioning and a recovery. Expectations are important. This pattern of decline and recovery is consistent across several domains of functioning. This is with adoptive families, however, where the plan is permanence. Although the model was conceptualized to explain the processes of readjustment among families who adopt older children, it may also have relevance for foster families, particularly therapeutic foster families who are trained in somewhat similar fashion as adoptive families. There are important differences though. One is that the length of the placement is uncertain, which may affect the process of relationship formation. Second, biological children in foster families may respond to the uncertainty of the placement and the removal of siblings as uniquely stressful. Third, unlike adoptive parents, foster parents are not empowered to advocate on their children's behalf. And fourth, for children in foster families, reunification with their biological parents is a possibility. That may affect how they enter families and how they maintain their relationships in foster families.

While the model has not yet been applied to foster family functioning, the limited literature in this area is somewhat consistent with predictions generated by the model. Families with less flexibility and unrealistic expectations experienced more problems, as did families with lower income and less experience. These findings are consistent with the model that suggests family flexibility, parental expectations, and resources may influence the readjustment to the entry. Siblings in the home who are already there must adjust to the entry of the child. Whether these siblings are biological or foster children also may impact the placement. Cleaver found that placements were compromised when the foster family had biological children under age five, or within two years of the foster child. Placements where unrelated foster children were in the same household tended to be more successful, suggesting that those having a network with other peers with the same experiences helped facilitate the adjustment. The presence of other family members, their role in the family, and their relationships with one another is another important part of family readjustment.

What about removal? Although foster parents work with their foster children, adjustment to the removal may be difficult. Unfortunately, there have been no studies that I know of reporting on family adjustment to the removal of a child. One of the important implications of a family-centered perspective for service delivery to children in foster care is that the processes of post-placement readjustment are transactional. We do not simply think about how the foster child adjusts, but how the child influenced the family and how the family is going to be influencing the child. Each family member faces the task of adjusting individually, diadically, and within the family system. Moreover, the child faces adjusting to a new community.

While we are in need of more research in this area, there are some implications that we can consider in terms of how we work with foster and adoptive families. Most importantly, what we need to think about is targeting families as a unit for case work in mental health services. Some of these services can include normalization of the processes of readjustment for both the entry and the removal, and can take the form of psychoeducational interventions or support groups. Support groups would also be useful to help foster parents cope with their lack of empowerment and perhaps with siblings who must contend with the stresses associated with opening their home and closing up after a foster child is removed. Given that foster children are entering homes with higher levels of behavior problems than before, all families should be trained in child management techniques. Case work services should be more consistently delivered to foster families. Knowledge about adjustment to the removal of a child and related influences can inform decisions about when to place another child with that foster family. Currently, we face the monumental task of revising the foster system to improve service delivery to the hundreds of thousands of children in care. As we do so, we must remain mindful of the critical familial contexts for these children and that we must provide supports for them, too. If we fail to do so, not only are we facing the potential of losing these families as important resources for foster children, but we also face adding damage to these families as well.

Pat Dubus: The Better Home Fund is kind of an odd-duck foundation in that we are grant makers but also researchers. Part of what we do is to translate research into policies and programs for the benefit of homeless families and children. In 1992, we embarked on an ambitious case-controlled epidemiologic study of 260 low-income housed women who had never been homeless and 220 homeless women living in shelters and their 600-odd children. A primary aim of the study was to identify individual-level risk factors that increase the likelihood that a woman heading a family alone will eventually become homeless. I will be talking to you about what we have

Family Support and Parenting

learned from that research, as well as what other kinds of research have taught us. We will look at the relationship between foster care and homelessness. Up until now, most research on the association between homelessness and foster care had involved single adults. We are one of the first studies that is looking at that relationship and many other things, as well, with families. There is an over-representation of people with foster care histories in the homeless population. Homeless people with foster care histories are also more likely to have their own children in foster care. Multiple foster care placements are more common in homeless people. People with foster care histories tend to become homeless at an earlier age. Part of this is foster children who age out of foster care and then become homeless. White people are somewhat more likely to have a foster care history than African Americans or Latinos. Generally, the speculation is that African Americans and Latinos have bigger kinship and larger families that can absorb some of the kinds of crisis situations that creates homelessness. Childhood placement and foster care can co-relate in a substantial increase in the length of a person's homeless experience. These people stay homeless longer with foster care histories.

One of the areas we looked at in our study of homeless women and housed low-income women was the childhood predictors of family homelessness. Many researchers have highlighted the significance of childhood disruption, trauma, loss, and other adverse childhood experiences, increasing the vulnerability to homelessness in both single adults and families. However, we found that both low-income housed and homeless women suffered from about the same high rates of disruption in their lives. What we did notice, however, were two startling exceptions. One was the use of drugs—not alcohol, but drugs—by the homeless mother's primary caretaker. The second was foster care, a history of placement as a child.

What is it about the foster care experience that would be so devastating? Why would it make someone more vulnerable to homelessness? From the research, we posit that the foster care system can fail to adequately deal with problems caused by sexual or physical abuse or troubled or dysfunctional families. It can fail to adequately deal with physical or mental health problems with children. Caregivers assigned by the foster care system can be abusive. These are all speculations that came out of the research. Multiple placements can preclude the development of nurturing bonds that have been shown to be critical to normal personal development. Institutionalization can be established as the normative lifestyle for children in foster care systems. Children in foster care may be unable to establish support networks that can carry over into adulthood. Foster care may improperly prepare children for emancipation.

I recently had the experience of a focus group with homeless and formerly homeless parents. The purpose of the group was to find out what they felt was needed in a good parenting program. One of the questions that was asked was about foster care. We were not prepared for how poignant, emotional, and affect-laden the material was around their responses to foster care. This leads me to believe that what can be so devastating to children is more basic and atavistic than any of the things that we have named before. I would like to present some of the vignettes from the transcript of that focus group.

This is Nadine. "I was in two foster homes. Once when I was seven, the other time I was eleven. Both homes were nice, and the people were kind. But the more they tried to include me in their families, the more sullen and withdrawn I became. I felt so disloyal to my mother and my sister if I found myself liking the foster family or having fun. One family was big on balloons. They used them as treats for anything from good grades to rewards for being quiet in church. I always let mine go, just sail off. I know the foster parents thought, 'There she goes again; she's just spittin' in our eye.' But that was never it. In my mind it was me sailing free."

This is from Leona. "When they took me to the foster home, I felt like a weed that had been yanked out of the ground and transplanted in a neat, tidy flower bed. They watered and fertilized me, but I knew I wasn't wanted there. I didn't want to be there either. I just wanted to be back on the roadside with the rest of the weed family." Again, there is that pull toward home, toward family, toward something of your own.

This one is from Pauline. "The social worker trying to cheer us up said that the foster parents were real nice and that they loved children. She could not have said anything more discouraging to me. I didn't want someone who loved all children; I wanted someone to love me above all children. When we lived at home, I think I did pretty well. I took care of my two little sisters and my mother who drinks a lot. When they put us all in foster homes, it was like taking away everything good about me. I was important at home; I mattered. In foster care I was just a case number, and I've never gotten my confidence back."

"The police came and got us and took us to jail. They gave us a lot of junk food while we were waiting for the social worker to come. I remember my poor little drunk mother crying on the steps of our house. I know she looked bad and I know we looked awful and neglected, but what they didn't know was how much she loved us and how much we loved her. As an adult, I can see why they thought we would be better off in a foster home, but I wonder. We may not have had enough to eat or wear, but we were a family, and we cried and we laughed together. Now mama has gone and no one is close anymore." *That is Angel.*

What I learned from that transcript was that we need to look carefully at our policies and our practices. How much more expensive is it to try harder at family preservation? Obviously, I do not think we will ever be able to not have foster care or something close to it. What I am concerned about, and going to be watching closely, is how we are going to erect policies that protect children, but do not disrupt families. It is a huge order, and Head Start is going to be a part of it.

Edith Fein: I would like to step back a little and give a historical perspective. Care for children outside their homes has traditionally been connected with three situations: abandonment, poverty, and abuse. Those three are often entwined.

In the Dark Ages, children literally were abandoned by the wayside. The surprising thing is that these children did not die; they were taken in through the kindness of strangers. In those days, children were a strong economic asset to the family. By the Middle Ages, we saw the establishment of foundling homes by the church. Unfortunately, the death rates in those foundling homes, particularly for infants and toddlers, was close to 100%. Gradually, communities, political entities, began to assume responsibility for destitute children. By the 1600s we saw in England the establishment of alms houses and work houses. Even in those days, distinctions were made between the deserving poor and the undeserving poor. Into the alms houses went whole families, and the conditions were dreadful there. They were so bad that children were soon singled out for rescue, and the rescue took the form of putting them out to the lowest bidder for caretaking. However, there were not enough bidders. It was not until 1875 in New York State that the children's law prohibited the placement of children in alms houses.

In colonial days we saw the proliferation of apprenticeships as a form of child care outside the home. There was a study done in Boston in 1805 that found that between 1734 and 1805 there were 1,100 apprentices, over half of whom were between the ages of five and nine. Poor children were put out particularly early, and many of them served this apprenticeship contract between 15 and 16 years before they were free to be on their own. This early form of foster care was both good and bad. The good was that the apprentices learned a trade, and they were taken

Family Support and Parenting

care of. The bad was that they were whipped, they ran away, and their families were bereft at their loss.

By the time of the Industrial Revolution, we began to see literally floods of orphaned, abandoned, and destitute children. Boarding out was one solution: boarding out in the homes of widows, usually supported by church funds, or boarding out supported by the state. We also began to see the establishment of orphanages. In this country the first orphanage was established in 1798. One study said that 20% of all children in 1900 were in orphanages. Between 1854 and 1929, we saw the phenomenon of the orphan trains. This was the situation where Charles Lohring Brace, the Protestant minister who was the head of the Children's Aid Society in New York, was rescuing children from the streets of the city and put them on trains with caretakers. The trains traveled out west, where farm families would come to the station and choose the youngsters that they wanted, breaking up sibling groups, with no regard for the wishes of the youngsters. These children were mostly Catholic children. In defense, the Catholic agencies began their own orphan trains. In the 50 to 60 years that the orphan trains were running, over 200,000 children were placed out of the City of New York.

Up to now I have been talking mostly about destitute children. In 1865 the Society for the Prevention of Cruelty to Children was established. The organization began investigating reports of child abuse, and when they found child abuse, they removed the children from the home and put them in orphanages.

By the end of the century, we began to see the rising tide of immigration. With the immigrants came working mothers and working children. Although the official working age was 12, that was honored more in the breach than in the observance. The alternative method of child care to putting the children to work was to have older children take care of the younger ones. That took them out of the educational system. We also began to see increasing use of extended families. There were stories in those years, as there are now, of kindness, and there were stories of cruelty and ostracism in those systems of care. In those days, child labor surprisingly was justified as good because it kept parents and children from being separated when they needed to work. With the immigration we began to see the rise of settlement houses, like Hull House in Chicago and the Henry Street Settlement in New York. We also saw the rise of kindergartens after 1850. The kindergartens and settlement houses became agents of social reform and agents of out-of-home care for children that started to be accepted more and more in society.

By 1933 we have 12 million unemployed people in this country. One study found that 20% of the children in the country were malnourished. Orphanages were growing at a tremendous rate. Children were roaming the streets, and the situation was dreadful. The New Deal response was many pronged. The National Recovery Act, which was passed in the early 1930s, prohibited homework and sweatshops for the first time and, in effect, reasserted the ideal of mothers staying at home taking care of their children. The New Deal also established WPA nurseries largely to create jobs for teachers, custodians, and nurses. They provided care for children who were outside their homes. The most dramatic legislation was the Social Security Act, establishing ADC, Aid for Dependent Children. We began to see a philosophic shift of money to support children rather than to support families who were taking care of children alone. Children were no longer seen as chattel.

These were the days of the teachings of Freud and of G. Stanley Hall, the developmental psychologist, which stressed the importance of good early child rearing. This gave further impetus to the growth of foster care. Children who were placed in foster care rather than orphanages were placed in suburban foster homes, because they were the ones that provided this good early

child rearing. That led to a geographic separation of families and the kind of divided motherhood, the divided families, the divided loyalties that we see endemic in foster care today.

World War II saw a tremendous increase in the employment of women, which resulted in the need for a place to leave their children. The Lanham Act was passed, setting up child care centers that were based on the old WPA nurseries, except that the Lanham Act centers were for all women and children to use, not just the poor. By 1945 there were Lanham Act centers caring for between 600,000 and 1,500,000 children, depending on which study you look at.

In the early 1960s, Henry Kempe published *The Battered Child Syndrome*, and that led to increasing recognition of abuse and neglect as a cause for removal of children from their homes. The number of children entering foster care then skyrocketed. By the 1970s we had almost 500,000 children in foster care. The situation was so dramatic that eventually we came to the passage of the Permanency Planning Act in 1980. The results of that act were so great that the numbers of children in care decreased by 50% within a few years. By 1982 there were only 225,000 children in out-of-home care.

I would like to touch briefly on the whole concept of orphanages. In 1909 there were 115,000 children in orphanages. The situation was considered so dire that the first White House conference was convened in 1909 by Theodore Roosevelt. The strong recommendation that came out of that conference was that orphanages be phased out and that family foster care be the placement of choice for children who had to be removed from their homes. It was not until 1951 that the numbers started declining. Between 1935 and 1960, the numbers of children in orphanages started going down and in foster care started increasing, but the total remained at about 250,000. The decline in orphanages was not so much because of the ideals espoused in the first White House conference; it was largely because the children coming into care were increasingly disturbed. That pressure of the increasingly disturbed children led to a feeling that the care needed to be professionalized. As a result of the influence of Freud and G. Stanley Hall, there also was a switch in emphasis from providing just physical care for the children to their rights to the appropriate care for their needs. At the same time, the deinstitutionalization movement in mental health came along. All of the factors leading to the demise of orphanages seemed to converge.

This was a quick run through history, but there are some lessons that we can pull out of it. We can be both pessimistic and optimistic. The pessimism is that the problems that we had addressed today have always been with us. How do we ever resolve them if we have not been able to do it up until now? The optimism, however, is that we have always been able to design remedies to deal with the difficulties that children have to face. Each of these remedies has had unintended effects leading to the need for further change. We can be optimistic that we can continue to do this work, but we need to be vigilant on behalf of our children.

John Hagon: I want to make a few comments. I also was a foster parent for over 20 years. I have worked with the different community units that one has to work with. I think the foster care system gets lots of bad raps, and I think that much of that is very undeserved. In one way or another, we are always going to have to deal with at least some children who are not living with biological family units. How can we do that best?

I have found through my experience in consulting with our agencies in my county and also in work with Rosalind in other counties, that the role of schools is terribly important. In any school you are able to find counselors, teachers, and often assistant principals who will be helpful.

Family Support and Parenting

Another is the whole area of medical service delivery, which is incredibly important. Of the children that I have had in my home and that I have also worked with, many have had major medical problems. You have to be able to work well with your medical service delivery people. In Michigan, we have gone through a transition over the last two to three years. All children in foster care are now part of an HMO in the whole State of Michigan. They no longer have to take a Medicaid card to go for services; they have an HMO card. The people at the clinic do not know unless you want to tell them that this child is a foster child or on Medicare. Instead, they get the same service that anyone else gets going to the HMO. Unfortunately, that has not extended to dentistry.

Probably the biggest issue is dealing with your Department of Social Services. The challenge is to figure out how to make that work. If some of you were with Head Start, you need to be well aware that all of the different units and agencies that these children deal with, and more, have to work, and they need to be orchestrated together. You need to find ways to make them work for you and your children.

The positive thing is that we are now getting a much better understanding through research and working with people in policy. The kinds of things that Rosalind and Ellen talked about give us good examples of the databases. Pat's work following up looking at the adults in the system retrospectively is extremely helpful and complementary. We are beginning to get a bigger picture, and we have to do a better job of communicating that, and even going beyond communicating—forcing people to listen and be responsive.

Audience Questions and Comments

Question: I was interested in your reference to deserving and undeserving poor. There has recently been a study of rural poverty, and it was casting a wide net to see what some of the dynamics were in communities. It was noticed that in many of the rural counties, the use of social services was markedly less than it should be for the percentage of the people in the population. Out of this big study emerged a dominant theme—that individuals saw themselves as deserving or undeserving. I wonder if the rest of you have seen that dynamic in foster care and adoptive care, in the immediate and the extended family and the broader community, in terms of how children are accepted or not accepted.

Ellen Pinderhughes: Two thoughts come to mind. The first goes back to a family example. The biological children in this particular family did not feel that these new adoptees were deserving of their parents' attention. This was in part because that family's system, the biological family system, had been a step-family system when we came into the picture, with a mother, stepfather, and four adult biological children. The biological father had died of alcoholism. The mother had been parented by these children. They were not willing to see these newcomers deserving of something that their mother was ready to give that they had not gotten.

One of the things that is typical among older adoptees and, I would think, among foster children is how undeserving children feel of care and protection. Some of my work is showing that, particularly in terms of some of the tendencies shown in their reliance on caretakers. They cannot look to them for having their needs met, or, if the caretakers attempt to meet their needs, they are not very successful. So they are not deserving of either having their needs met or of having their needs met sufficiently.

Question: I wanted to know if you had a sense of how many children in your studies had prenatal drug exposure, and if you did have some of those children, did that have an impact on the expectations of the prospective foster parents, adoptive parents?

Ellen Pinderhughes: In my sample, the case records did not indicate any prenatal drug exposure. Coming back again to the family that I referred to, a youngster who disrupted early out of that sibling group did have severe ADHD. The adoptive mother, being a nurse, felt that it made sense to titrate him off the medication and try behavioral strategies. Where the expectation piece comes in, not tied to prenatal history but to his early history, is that she was unwilling to pay attention to the signs that were there before he was placed. She chose instead to rely on her training and her own conceptions about how this child should be functioning. This was an example where the expectations were linked not to prenatal drug use but to functioning and her interpretation of what influences there were.

I want to add one thing on drug-exposed children coming into foster care. I did hear some-one present research on cocaine-exposed infants who were in care, and they followed them into the first and second grade. The children were all in care, but some of them had multiple placements and some of them stayed with the same foster parent. They found out that the problems that drug-exposed children showed were not related to the drug exposure, but they were related to the repeated attachment disruption. The problems caused by cocaine that cause damage to the brain can be taken over by other parts of the brain. That really was not the problem. It was the placements.

■ Parenting in Early Intervention Programs: Program Goals, Effects, and Measurement Strategies

Chair: Lisa J. Berlin, Dafna E. Kohen

Discussant: Sheila Smith

Presenters: Martha J. Zaslow, Jean Layzer, Robert St. Pierre, Dafna Kohen

The tradition of early intervention began in earnest as part of the Johnson Administration's "war on poverty." Since the mid-1960s, many early intervention programs have been undertaken, with Head Start as one of the time-honored prototypes. Following the Head Start model, most early interventions have been designed to promote poor children's school readiness. Within these initiatives, although parents are readily acknowledged as playing a central role in their children's development, and parent involvement has proven to be a cornerstone of Head Start and other programs, until quite recently, relatively little attention has been paid to either 1) differentiating program goals related to parents' development from their goals related to children's development, or 2) evaluating the direct effects of such interventions on parents. In this symposium, we presented work along both of these lines. Additionally, we addressed the issue of the measurement of parenting within early interventions.

The Symposium consisted of three papers followed by a discussion. The first speaker presented new data from a multisite, longitudinal early intervention study of low-birthweight infants on intervention effects on parenting attitudes and behaviors. The second speaker described results from a recently completed "two-generation" intervention designed to promote both maternal self-sufficiency and children's development. The third speaker discussed observational measures of parenting behavior and presented data that may have implications for the design and evaluation of future interventions, especially those following a two-generation model. The discussant integrated these presentations and suggested directions for research, practice, and policy.

Examining Observational Measures of Emotional Support and Cognitive Stimulation in Low-Income, African-American Adolescent Mothers and Their Preschool-Aged Children: Implications for Evaluating Early Intervention Programs Lisa J. Berlin, Martha J. Zaslow

The study of parent-child relationships encompasses many different theories and measures. Faced with a multitude of approaches, researchers must question carefully the extent to which assessments overlap and the extent to which assessments tap distinct aspects of a complex whole, even, for example, within a single dimension of parenting behavior. These questions are particularly relevant for evaluations of early intervention programs, as rigorous evaluations of such programs are important for demonstrating the strengths and limitations of particular programs and particular services for particular families. This type of information should, in turn, help programs help families.

In the study reported, we drew on data from two intervention programs to examine observational measures of parenting behavior in poor, African-American adolescent mothers and their preschool-aged children. We had three goals: to closely examine observational measures of parenting behavior; to do so within a vulnerable population frequently targeted or at least included in early intervention programs (i.e., adolescent mothers); and to consider the implications of our findings on ways in which researchers measure parenting within evaluations of early intervention programs.

Data for the present study came from two investigations, the Newark Young Family Study (NYFS) and the Infant Health and Development Program (IHDP). Within both of these studies,

we examined observational measures designed to tap two broad dimensions of mothers' parenting behavior: mothers' provision of emotional support and cognitive stimulation. Two principal observational measures of parenting behavior within both of the studies included were the HOME Inventory and a series of mother-child interactions, including a free-play assessment (in the NYFS) and a problem-solving assessment (in both the NYFS and the IHDP). Whereas both the HOME and the mother-child interactions comprise different "lenses" through which to examine parenting behavior, both assessments also include scales that can be viewed as reflecting mothers' emotional support and cognitive stimulation. We examined these measures in relation to one another and in terms of their associations with two important aspects of early childhood development: receptive language abilities and children's behavior during problem-solving.

Correlation analyses revealed modest associations between the two emotional support scales and between the two cognitive stimulation scales. Looking across both studies' regression analyses, the HOME subscale was associated with child behavior in half of our regression analyses. However, in seven of eight (88%) of our regressions, the mother-child interaction scale significantly predicted child behavior above and beyond both the sociodemographic factors and the relevant HOME subscale.

Taken as a whole, our findings highlight the independence of the parenting scales considered, and the importance of drawing on multiple measures of parenting behavior. This is especially true for assessments of parent-child interaction and understanding parenting in low-income, teenage African-American mothers of preschool children. This is a population frequently targeted by early intervention programs. One way to help early intervention programs stay afloat and help their communities (and better help their families) is to provide high-quality information to the programs and the research and policy communities. In this study, we shed some light on how to collect that high-quality information.

Early Intervention Effects on Parenting Attitudes and Parenting Styles

Dafna E. Kohen, Donna Spiker

This study examined the effects of the Infant Health and Development Program on parental knowledge of child development, parental perceptions of children, and parenting behaviors. While evaluations of the effects of early intervention programs have paid little attention to measuring parental knowledge of child development and maternal attitudes, this area could illuminate the process by which effects of intervention programs influence parental behaviors, thereby indirectly influencing children. By gaining an understanding of how intervention programs influence parenting, we can gain an understanding of how to sustain treatment benefits.

Different aspects of parenting mean different things for different groups. For example, in a small sample study, Baumrind suggested that certain types of parenting are beneficial for Whites while others are beneficial for African Americans. In a recent study on the IHDP by Kohen & Spiker, different characteristics were found to be associated with parenting depending on race. For example, lower levels of income were associated with punitive parenting among Whites, whereas younger maternal age was associated with punitive parenting among African Americans. Data show that White mothers also do better than African Americans on measures of maternal knowledge and parenting behaviors. This suggests that different processes are operating for each of the two groups, or measures mean different things for different races. Since these differences exist, this study examined the effects of intervention on African-American and White subgroups separately and addressed the following questions: 1) is there an intervention effect on maternal

Family Support and Parenting

attitudes and maternal knowledge; and 2) is there an intervention effect on parenting behaviors and parenting styles exhibited in different situations?

The IHDP intervention had a significant effect on maternal knowledge and parenting behaviors of White mothers, but not of African-American mothers. Among the White mothers, the IHDP intervention was associated with more positive parental behaviors displayed in two different situations. That is, treatment effects were associated with higher ratings of quality of assistance in a puzzle task. White mothers who participated in the IHDP were also associated with higher ratings of a warm and respectful parenting style (Authoritative) and lower ratings of a harsh and punitive parenting style (Authoritarian) in a free-play task. The intervention was associated with increased maternal knowledge of child development and benefits in the parenting styles in the lowest income groups of White mothers. A possible explanation for the racial effects obtained include differences in the economic situations of the two groups. There was differential income distribution, with Whites more likely to be at the higher ends of the income distribution, and African Americans more likely to be at the lower ends of the income distribution.

Between Parenting Education, Parent-Child Interactions, and Child Outcomes

Jean Layzer, Robert St. Pierre

Paper summary not available

The Complexity of Program-Parent Interactions *Miriam Westheimer*

Paper summary not available

■ What Do We Know about Enhancing Parent/Child Communication and Interaction with Infants and Toddlers?

Chair: Kathryn E. Barnard

Discussant: Robert Emde

Presenters: Kathryn E. Barnard, Colleen E. Morisset, Susan Goodwyn, Scott McConnell

This symposium contributed the most current information about early language intervention for normal and at-risk infants and toddlers. Language and communication are both important processes and outcomes in the earliest years of development. Children who can maintain their communication and language skills during the toddler and preschool years have an advantage in mastering the reading, writing, and verbal communication required as they enter primary school. Primary prevention directs us to the early months of life to begin helping parents or primary caregivers create the best conditions for infants as they learn and develop their communication and language skills.

The four presentations demonstrated specific intervention techniques: state modulation for the unresponsive infant, dialogical reading for the toddler, symbolic gesturing for the nonverbal child, and specific adult behaviors to share activities, request language expansions, and provide exuberant and positive feedback to preschool children with low stable rates of talking. The studies involved both normal children and children at risk. The enhancement studies demonstrated positive outcomes in terms of communication. Overall, the studies not only demonstrated the importance of the parent-caregiver-child relationship, but also suggested an interactive effect with findings related to the specific developmental level of the child and/or individual differences. The important factor appears to be matching the intervention to the individual differences of the dyad related to risk or age.

Infancy-Promoting Optimal States for Interaction: A Trial with Low-Birthweight Infants

Kathryn E. Barnard, Rebecca Kang

Preterm infants are less responsive to their caregiver during the first few months of life. During feedings, they seldom open their eyes or show the type of organized behavior demonstrating hunger or fullness that term infants show to their parent/caregiver. This lack of responsiveness is thought to be related to their behavioral state organization. They show less organized states of sleep or wakefulness, and they have more difficulty getting from a sleep to an awake state. They have less organization in sleep states shown by physiological as well as behavioral parameters. For example, the physiological parameters of heart rate, respiration, and brain activity do not show the clear relationship within a state. In quiet sleep there should be slow brain waves and regular heart rate and respiration, but the preterm infant may show irregular breathing along with the slow brain-wave activity and regular heart rate.

When the infant is in a quiet alert state, the organization of the central nervous system is best. It has been observed that the preterm infant under six months of age has fewer periods of alertness, especially in the first months after birth. This reduced alertness makes the infant a less responsive social partner and also contributes to more difficulty with feeding. In indeterminate sleep states or transitional states the infant does not suck as well. The sucking pattern is not as organized and the sucking is less efficient. Being in an alert state improves the sucking and, in general, makes the infant more responsive.

Family Support and Parenting

Several studies demonstrate that gently waking the baby before feeding improves interaction and feeding effectiveness. Specific research was done in three cities and involved public health nurses teaching parents how to modulate their preterm infant's state prior to feeding. The design of the study was an experimental design with subjects randomly assigned to treatment (state modulation) or comparison (infant seat positioning) groups. The data came from subjects where the parent had at least a high school education (Experimental group N= 64; Comparison group N=70.) The results demonstrated that the state modulation group (treatment) was more responsive at 46 weeks on the Nursing Child Assessment Feeding Scale than the infant seat positioning group (comparison); they also demonstrated a maintenance of the positive interaction for both infant and parent at five months on the Nursing Child Assessment Teaching Scale. Thus, parents of preterms who had been exposed to modulating infant state prior to feeding, immediately upon discharge from the Neonatal Intensive Care Unit, had infants who were more responsive and whose feeding interaction was positive within the first few weeks than did parents of preterms who had not been exposed; this positive interaction also influenced later interaction patterns at five months of age in a nonfeeding situation where the mother was instructed to teach the child a new task. The experimental dyad had better interaction in both the 46-week feeding and the five-month teaching observation.

The research suggests that altering the early responsiveness of the preterm infant does enhance future parent-child interaction and, in turn, is a good predictor of the child's future cognitive performance. Quality parent-child interaction is an important factor for promoting positive child cognitive and language outcomes.

"Mommy, I wanna read to *you* now": Strengthening Child Language Skills by Listening

Colleen E. Morrissey

In 1994, 5.6 million American children lived in poverty despite the fact that one or both of their parents worked year-round. For these and other families, the problems of too little time for parenting and too little money for adequate child care are daily realities. As interventionists, we must acknowledge these constraints, and "work smarter" on behalf of the families and young children.

This presentation summarized two studies of an intervention that exemplifies "working smarter." The intervention, called "dialogic reading," teaches parents to read story books with their toddlers in a way that enhances children's vocabulary and sentence-level skills.

Study 1. The Seattle study took the form of a randomized control study. The librarians of children were taught to provide training in dialogic reading to small groups of parents. The effect of the intervention was compared to a control condition in which parents also met with the children's librarians, but were not introduced to specific ways of reading with their children. A total of 129 families were randomized to the intervention and comparison groups. Child language assessments were conducted before and after the intervention period and, for approximately one-half of the sample, at a three-month postintervention follow-up. Analyses revealed the following conclusions: 1) the reading behavior of parents and children in the intervention group changed significantly relative to the comparison group, and to their own pretraining reading style; 2) compared to children in the intervention condition, children in the control condition were two to three times more likely to show lags in expressive language skills one month following the intervention phase, and this pattern was still evident at the follow-up testing; and 3) parents in the treatment

group reported a greater reduction in parenting stress over the course of the study period, due to difficult characteristics of the child.

Study II. The purpose of the second study was to learn whether the intervention could be adapted to communities where many children are at risk for language delay and eventual school difficulties due to widespread poverty. Approximately 60 families from two socioeconomically disadvantaged communities, Fremont County, CO, and North Lawndale (Chicago), IL, participated in this study. Paraprofessionals were responsible for recruitment and parent training within each community. Evaluation took the form of structured parent interviews and pre- to posttest changes in children's exposure to reading and language skills. Two important findings came out of the study. One, following the intervention, parents' responses were overwhelmingly positive. The most frequent comment was that they liked the time they spent reading with their children, and they enjoyed the physical closeness and the positive involvement. Two, children's orientation toward reading and language skills also changed over time. Compared to baseline, more children were read to on a regular basis, and parents indicated that their children enjoyed reading more than they did before the intervention. In short, this study showed that the intervention is portable to communities with different types of family resources, and that a wide range of families are attracted to the intervention and actually use it in their homes.

Baby Signs: The Research Evidence of the Benefits of Teaching Gestural Communication to Infants and Toddlers *Susan Goodwyn, Linda Acredolo*

The research described represents an example of how basic research in psychology can yield information with clear practical implications for the larger community. The work documents the existence and effects on development of a phenomenon known professionally as "symbolic gesturing" and colloquially as "baby signs." These gestures, purposefully modeled by parents or caregivers, are easier for babies to learn than words but function in many of the same ways: labeling objects (e.g., arm-flapping for "bird"), expressing needs (e.g., thumb to mouth for "bottle"), or describing events (e.g., blowing for "hot").

With the help of a four-year grant from the National Institute of Child Health and Human Development, we followed approximately 140 infants from 11 to 36 months in order to determine the effects of symbolic gesturing on development. One third were encouraged to learn gestures, while the other two thirds were not. Results indicated positive effects on verbal language and cognitive development. Specifically, babies who were encouraged to use symbolic gestures progressed faster, as measured by standardized tests at 15, 19, 24, 30, and 36 months in both their comprehension and production of vocal language. Perhaps of even greater importance were the positive effects on parent-child interaction that parents of the gesturing babies described. Among the latter were reports of lower levels of frustration, greater appreciation of infant abilities, a stronger parent-infant bond, increased interest in books, and greater involvement by older siblings in the baby's care.

Developing Services for Children Exposed Prenatally to Drugs and Alcohol: Using Research Results for Intervention Design

Scott McConnell, Mary McEvoy, Karen Rush, Judith Carta, Jane Atwater, Rosanne Williams, Charles Greenwood

For the past decade, educators, parents, practitioners, and researchers have expressed concern regarding the developmental consequences of prenatal exposure to cocaine, alcohol, and other drugs. Recent research documents that the relationship is far from simple; rather, the rela-

Family Support and Parenting

tionship between prenatal drug exposure and developmental outcomes appears to be mediated by a host of environmental factors and to vary as a function of child age and domain of concern. Several recent studies suggest, however, that language, communication, and early literacy skills for this population may be areas of special risk. This paper presented an empirical approach to intervention development and validation for children exposed prenatally to drugs and alcohol.

In Study 1, preschool-aged children with positive histories of prenatal drug and/or alcohol exposure were compared to similar children with no known exposure. Review of results from standardized assessments indicated, as a group, most significant delays in the areas of communication and cognitive skills among those in the exposed group. Further, scores on these measures were significantly correlated with direct observation measures of child verbalizations in home settings. Finally, review of observational records demonstrated highest rates of child verbalizations when adult caregivers were in close supervision or shared activities with the child, and when the caregiver requested language expansions or provided positive and exuberant feedback.

These descriptive data were used to develop a parent-training intervention in Study 2. Four children demonstrating delays on standardized language measures and low rates of observed vocalizations participated, along with adult caregivers, in a multiple-baseline experimental evaluation. Following baseline, where low and stable rates of talking were demonstrated for three of the four subjects, caregivers were asked to share 1 of 15 predesigned play activities. Observational data indicated some increase in level and variability of child vocalizations for all four participants. Finally, caregivers were provided activity-specific suggestions to share activities, request language expansions, and provide exuberant and positive feedback. During this final phase, increased and stable rates of verbalization were noted for all four children. Some evidence of maintenance of effects was provided. Results were discussed in terms of development of home-based language interventions for multirisk families.

■ Biological and Environmental Factors That Influence Child Development

Chair: Jack Pascoe

Discussant: Ruth Etzel

Presenters: Betsy Lozoff, Peter Briss, Benjamin Gitterman

Benjamin Gitterman: What is amazing to me in looking into this field is the minimal amount of information that the public and the health and educational professionals know about the subject of secondhand tobacco smoke and its effect in general. That runs the gamut from what I can find or cannot find on the subject in the lay press, to what happens when I ask the families of patients whom I treat. I cannot believe there is almost anybody left in the United States who is not aware of the effects of direct cigarette smoking.

Here is a significant list of the major clinical effects of secondhand smoke in children that we are aware of:

1. Asthma and what some people might call minor respiratory illness—what some might write off as the flu. It is primarily some aspect of bronchospasm or tightening of the air tubes and causes wheezing in children. Depending on the severity of it and how intensely someone assesses it clinically, it can have a variety of manifestations and can be defined as a variety of different diseases.
2. Middle ear disease—ear infections, whether it be clear fluid such as cirrus otitis media or whether it be acute otitis media, are very dramatically related to the presence of secondhand cigarette smoke.
3. Sudden Infant Death Syndrome (SIDS). There is much data strongly relating SIDS and secondhand smoke exposure to the home of a child.
4. Low birthweight. This has been looked at in terms of both the mother and the father smoking. That is secondhand smoke before the child is born, but it is still secondhand smoke.
5. A variety of other conditions. There is research that links brain tumors in children with secondhand smoke, as well as a wide variety of skin conditions.

Particularly with the first few, if children have an acute illness, they are invariably sidelined. Although children in general—healthy children—are dramatically resilient and can bounce back far better than adults, on the immediate acute level, they get wiped out easily. Being home sick deprives the child of learning experiences at school. Even at school, the sick child cannot gain a lot. Therefore, acute illness ends up having a dramatic impact on the developmental status of children. The bottom line is that children in environments where there is smoking have an increased risk of wheezing. Wheezing triggers asthma, or triggers clinical bronchiolitis, potentially in viral illness season, making it far more likely that children are going to be at home, sidelined. Even if they are not at home, it is more likely that they are unable to take in the stimuli around them and effectively move ahead developmentally.

In the most common ear infection, or purulent otitis medias, particularly, the ear is bulging out. There is fluid in the ear. Whether there is an acute infection or a simple effusion that is not infected, the fluid is impeding the transmission of what eventually will produce sound in the child, and the child cannot take in very much. It is obvious that hearing impairment has an impact on a child's development.

Health, Mental Health, and Resiliency

If you compare a relatively normal audiogram to the audiogram of a child who has a hearing abnormality, you can see that they are not able to hear at the frequencies that they need to hear. The impact on sound and, therefore, on learning can be dramatic. It is not dramatic enough potentially to be known clinically by someone in a room; the child may not say anything or may not be exhibiting any notable behaviors, but may have a mild hearing impairment. It may be short term or for a long period of time. It can be for weeks on end, not necessarily just days. There are different developmental impacts of different levels of hearing loss. This can run the gamut from a child who can hear normally all the way down to a child who may need special education because of their hearing impairment. Ear infections can dramatically impact on this.

Incidences of SIDS in both early SIDS—the 70- to 90-day period after birth—and later SIDS is quite different in households where there is nonsmoking versus households where there is smoking. Mean birthweight in terms of low-birthweight infants is also affected by secondhand smoke. It is affected by the mothers smoking in the home. There is some suggestion that fathers smoking may have an impact as well. However, the data seems to be more reliable with mothers. I do not want to lie to anybody and say that when all the factors are isolated out, you are going to have a one-pound baby when the mother smokes and a five-pound baby if the mother does not smoke. Based on the cotinine level measured in the saliva in the mother, there may be a 100-gram differences in the birthweight of the child whose mother smokes. In addition to other factors in the environment, this could potentially produce some negative effects. We have enough developmental experience to appreciate what the impact of low birthweight may be, particularly the multifactorial influences that may be affecting a child's development.

In the early childhood education arena, the American Academy of Pediatrics, Pennsylvania Chapter, has a kids- and staff-friendly program, an extension of a program of the American Cancer Society. It includes workbooks and coloring books as a staged educational program for teaching children about secondhand smoke. It includes a videotape for parents and child care workers and a questionnaire. It is designed to make a dramatic impact on larger numbers of people about the effects of secondhand smoking. This program has been distributed in about 400 sites in Pennsylvania. The National Resource Center for Health and Safety in Child Care, in conjunction with a grant from the Environmental Protection Agency, is now looking to modify this program to make it even more user-friendly and usable with various cultural groups. They are planning a free distribution of this program to large numbers of people. This will be happening over a several-year period. If anyone is interested in finding out about the module and how to get it, or in participating in their regional area, you are welcome to contact me directly.

Lastly, in the child care setting, if some of these effects on development are real, what can child care providers do? They can support no smoking anywhere in or around the child care facility. In spite of the 1994 law, which says that there is no smoking in child care facilities except in a room that actually has specific ventilation systems, there is a surprising amount of smoking going on right around child care centers, if not directly in the child's face. The ways to begin to get people to stop smoking are using positive approaches; reminding them about the effects of secondhand smoke; and helping children to practice saying no. For any of you who are not in the clinical practice of medicine, it is a real joy to be sitting in a room taking a routine history with a three- or four-year-old child and asking the parent if anyone in the family smokes. The parent, sometimes comfortably, sometimes uncomfortably, says, "No, I do not." Then the child perks up, "Yes, she does; she just doesn't want to tell you, and I tell her it's bad."

We cannot say that because someone smokes, there is medical illness, and medical illness subsequently leads to developmental abnormalities. However, we do know enough about health

and developmental changes to realize that if smoking affects health, and health affects development, there has got to be a significant link.

Peter Briss: The prevention of lead exposure in the United States is a dramatic public health success story. There have been a number of concerted and continuing public health actions: instituting screening programs that identify and treat lead-exposed children; reducing lead sources in the environment; taking lead out of gasoline; essentially banning the use of lead-based paint in homes; and educating the public about lead and how to avoid it. We have made great strides in reducing lead exposure and morbidity. There has been a dramatic drop in blood lead levels among U.S. children, going from an average of about 15 micrograms per deciliter to an average of about 4. In conjunction with this improvement in blood lead levels, we have also seen a great decline in lead-related morbidity and mortality. In the 1960s in Chicago—just one city—there were 20 lead poisoning deaths every year. Today, nationwide, there is one such death yearly. In spite of progress, lead is still an issue: 1.7 million American children, or nine percent of children who are younger than six, have elevated blood lead levels, defined as greater than or equal to 10 micrograms per deciliter. Some children are more affected than others. More than a third of children who are poor, African American, and urban have elevated blood lead levels. There are large reservoirs of lead in children's home environments to which they can be exposed. There are still 57 million U.S. homes that have some lead-based paint in them.

Question: Do you know when lead-based paint stopped being produced?

Peter Briss: It was essentially banned in 1978. Lead is an element, and so there is a little bit of lead in anything you can imagine, but the traces that are still in paint are trivial. Any of us can be exposed to lead, but children are most vulnerable. That is because children are more likely to be exposed to lead. Children, as part of their natural exploration of their environments, put hands and objects and almost anything you can name in their mouths. When the hands or objects are lead-contaminated, they get lead into their systems that the rest of us do not get. Once lead gets into their systems, children are better at absorbing lead than adults are. Once they absorb the lead and get it into their bloodstreams, their developing brains are more susceptible to lead's toxic effects than the brains of older people. So for all those reasons, children are at highest risk.

What are they at risk of? What are the health effects of lead? Very high blood lead levels cause serious clinical problems. Lead levels over 50 micrograms per deciliter cause problems with blood-forming organs, kidneys, and the central nervous system. Blood lead levels over 70 micrograms per deciliter cause convulsions, coma, and death. There is considerable recent epidemiologic evidence that suggests that lead causes subtle problems with learning and behavior at levels as low as 10 micrograms per deciliter. There is no biological benefit of lead. And there may be no threshold for some of the adverse effects of lead. There may be no safe level. This is not just based on epidemiologic studies. There are a number of lines of evidence that suggest that lead may cause developmental problems. First, we know that lead gets into the nervous system. We have heard already that when the levels are high enough, lead causes serious clinical nervous system effects like convulsions and coma. Second, there are a number of laboratory studies that suggest that lead causes problems for nerve cells and neurotransmitters. Last, studies of monkeys where blood lead levels can be experimentally controlled, show problems with learning at levels as low as 10 or 15 micrograms per deciliter. All these lines of data suggest that it is plausible that lead might cause problems for children's learning.

Health, Mental Health, and Resiliency

Do the findings of human studies consistently document these plausible adverse effects? The answer is yes. However, every study does not give exactly the same answers. There are many reasons for this, and I am going to go through some of them. First, the studies differ in how they measure exposures to lead. I mostly talk about blood lead levels because those are the most clinically useful measure of lead exposure. However, blood lead levels are limited in the sense that they measure just recent exposure over the last month or so. There are other measures that give you a different look at lead exposure. Lead gets stored in tissues like teeth and bones. We can look at lead concentrations in teeth or bones and get a sense of lifetime exposure to lead. It is not surprising that you might get somewhat different results depending on how you measure exposure. Second, studies also differ in the ways they measure outcome. There are many ways to measure learning or behavior in children. Depending on how you measure learning, attention, or behavior, you can get somewhat different results. Third, both lead exposure and developmental measures differ dramatically with age. Depending on the age of the population, you can get somewhat different results. Fourth, the kinds of study populations that have been looked at in lead studies are extraordinarily diverse. We have looked at children that are relatively advantaged and relatively disadvantaged. We have looked at children of a variety of races and ethnicities, from a variety of cultures. We have looked at children on a variety of continents. It is too simple to think that all these studies would always get the same answer. And finally, investigators have represented a variety of disciplines, backgrounds, and interests. Therefore, you would not expect necessarily much consistency among studies, and, given this diversity, there is remarkable consistency.

There are studies that show the relationship between intelligence test scores and increase in blood lead level. As blood lead level goes up across studies, the general pattern seems to be that intelligence test scores go down. One way of trying to summarize data across studies is by doing a meta-analysis. There are three meta-analyses that have looked at the relationship between lead exposure and I.Q., and all of them show that as lead exposure increases, I.Q. goes down. These are not big effect sizes. The change in I.Q. with an increase of a blood lead level by 10 micrograms per deciliter seems to cost people something like one to three I.Q. points in most studies. There has been quite a hue and cry about whether that is a big enough difference to make a difference.

We are going to suggest that it is a big enough difference to make a difference for the several reasons. One reason is that these are averages, and real people are not averages. This researcher is illustrating the problem by managing to drown in a pond with an average depth of three feet. The second thing is that small changes in I.Q. are of particular significance for people that are either very high in I.Q. or very low. There is a big increase in the proportion of children who have I.Q.s below 80. There is also a big decrease in the proportion of children who grow up to have I.Q.s over 120. This is of consequence societally.

Another thing to keep in mind is that even in the middle, these differences in I.Q. may not be huge, but there are many economic studies that suggest that the higher your I.Q. is, the more you are likely to earn over the course of your lifetime. This is not a shocking finding. It is likely that economies are going to move more toward rewarding work that is intellectually demanding and penalizing people who cannot do that kind of work. It is incumbent on us to maximize everyone's potential.

Question: What puts children at great risk for exposure? Is it toxic waste sites? Is it lead-based paint in their homes? If you look at the kinds of children who are at risk across the spec-

trum of studies, what puts children at greater risk even now when we have reduced lead so much? What policy can we begin to institute to be very aggressive about trying to eliminate that risk?

Peter Briss: The question is where lead comes from and what can be done about it. You can be exposed to lead from a variety of environmental sources. Lead has been used in gasoline. That is not being done anymore, but it did get deposited in soil and dust, for example. We used to get more lead in food than we currently do. We have made a number of regulatory approaches, like banning lead solder in cans. You can get exposed to lead from occupations that use lead and from industries that use lead. All of those are important for some children. In 1996 in the United States, the biggest remaining reservoir of lead is lead-based paint in housing. It is not just the presence of lead-based paint on the walls. It needs to be deteriorating so that children can get it into their mouths.

Question: If I want to renovate an old house and rent it out to a low-income family, what can I do to make sure that the children are not exposed to lead?

Peter Briss: Dealing with all the lead paint in the 57 million houses that still have some is a problem that we are going to struggle with for a long time. There are a variety of complementary approaches that need to happen that are going to help us make some progress. People need to know what the hazards are and how to avoid them. There are regulatory approaches that are going to require disclosure of potential lead hazards to families before they move into new housing. That is going to start this year. There also needs to be financial help to get some of this housing worked on. A variety of public and private sector people are trying to work on how to finance that kind of work. There needs to be better scientific work that helps us to determine how best to effectively and cost-effectively deal with those kinds of problems.

Question: What if I strip off the old paint with paint stripper, and paint it over with new paint?

Peter Briss: You are liable to make things worse.

Comment: To do it right is so extremely expensive, and it creates this dust. You have to have very serious environmental equipment, and the owners of the houses where this kind of paint are do not have that kind of money.

Peter Briss: That is kind of conventional wisdom. In 1996 we are in a better position than we have been traditionally to minimize lead hazard without bankrupting either individuals or us collectively. We can maybe do better, but I do not mean to discount the difficulty of that.

Betsy Lozoff: I am going to talk about iron-deficiency anemia and behavior and development. In starting, I want to indicate that these studies have been done in three different Central and South American countries. In Guatemala, I worked with INCAP, which is the Institute of Nutrition for Central America and Panama; in Costa Rica, with the National Children's Hospital; and in Chile, with the Institute of Nutrition and Food Technology at the University of Chile.

The first question everybody might have in their minds is why I have been doing all of this work outside of the United States. There are actually several reasons. The time that I began doing

Health, Mental Health, and Resiliency

research was in the late '70s. We had instituted the WIC program in the United States in the early '70s. Even at that time, we were already making a huge impact on the iron status of children in the United States, with the WIC program providing iron-fortified formula, iron-fortified cereal, and juice that has ascorbic acid that increases iron absorption. There was a tremendous shift to encourage breast feeding. All of these improve the iron status. That was one problem about studying it in the United States. The second was where we had iron deficiency in the United States, we tended to have it coinciding with high lead levels. Often it was in African-American populations where there are hemoglobinopathies, which make it very difficult to distinguish on screening whether the child has, for example, an alpha-falciemia trait or an iron deficiency. For those reasons I was looking for settings where I could, as best as possible, isolate iron deficiency from other factors.

I would like to focus on some conceptual issues. One is going beyond developmental test scores as we think about what iron does. Another is trying to consider what we know about central nervous system effects. Also I would like to look at the description of children's behavior, not just their Bailey scores. Then I want to come back to the issue of the confluence of biological and environmental risk. In that point I will be using iron deficiency as an illustration, but, in fact, it is a dilemma common to generalized under-nutrition, failure to thrive, abuse and neglect, prematurity, low birthweight, elevated lead levels, and other nutrient deficiencies. So although I will be using iron deficiency as a case illustration, the issue is much broader in terms of the question of how biologic influences affect development.

There are over 500 studies looking at the worldwide prevalence of anemia. Forty per cent of the world's children are anemic. In these 500 studies, there were not many studies of infants. It is not easy to get a simple worldwide percentage. However, for the prevalence in infants, it is even higher than in childhood. Across the world, half of all anemia is due to iron deficiency. The best estimates for the worldwide prevalence of iron-deficiency anemia in infants is 20 to 25 percent. If we consider the earlier stages of iron deficiency before you get to anemia—the last stage—we are probably talking about approximately half of the world's infants with iron deficiency.

In the Center for Human Growth and Development at the University of Michigan, one of our themes is growing up in poverty: its effects on children's health and development, both in the United States and in developing countries. There are two "boths" in that theme. One is both health and development. That is coming back to Zigler's comments—that so many times you see studies that look at only one or the other, and we are trying to bring those people together. The second is that as we think about children in poverty, again researchers divide themselves—those who are thinking about developing countries and those who are thinking about the poor in the United States or in advanced industrialized societies. We are missing opportunities because people who thought about it from different viewpoints are not talking with each other. My research on iron deficiency is part of that focus at the center at the University of Michigan, and I am trying to bring together some of these cross-cutting ways of thinking about things.

This is what we know about developmental test scores for iron-deficiency anemic infants. In the past 20 years there have been 17 studies of iron-deficient infants. However, as with many other fields, they do not all have the same criteria or the same study design. Seven of them had infants with iron-deficiency anemia where the iron status was well defined and had control groups. All seven of the studies found that infants with iron-deficiency anemia have lower mental test scores, and five of the seven found that they had lower motor scores as well. In terms of fol-

low-up studies, when the children are at school age, there are even fewer studies. In any scientific field, it takes a lot of research before you know with confidence what the answer to questions are.

As we think about what could be going on, people have thought it had to do with the brain. The biologic plausibility that Peter was talking about again comes in here. In animal work you see changes in neurotransmission in iron deficiency. These are the systems that have been implicated. Dopamine is by far the best studied and by far the clearest evidence. In the animal model, you can do effective things with drugs that either block or enhance various stages of any neurotransmitter. Using that kind of technique in the animal model with iron deficiency, you see dopamine-mediated changes in motor activity, temperature control, behavioral responses, pain threshold, the endocrine response (particularly prolactin), and learning. Some of these effects are irreversible insofar as studies have been done. In the animal model, there have been consistent studies that when iron deficiency occurs early in development, you get a deficit in brain iron that is not corrected with treatment, even though the liver iron and the blood iron go back to normal. It is a deficit of about 28% to 35% of brain iron. As you look at the dopamine story, there are decreases in one of the receptors for dopamine in the brain, the dopamine D2 receptor. That is not corrected with treatment. I have wanted to be able to study anything to do with dopamine in the human infant. It continues to be very challenging. The best we have been able to get at are some of the prolactin questions. Talking with my colleagues in cognitive neuroscience, we are beginning to think we are identifying some behavioral tests that are dependent on dopamine.

The other area that is now being recognized where iron is doing something in the brain is with myelin formation. Myelin is the fatty acid coating that goes around nerve cells that allows the nerve message to get conducted much more rapidly down the nerve channels. This is critical in development. It is why children cannot walk initially, but they can walk later on; why they get sphincter control later on. As the nerve fibers get myelinated, there are leaps in development. In the last five years, iron in the brain was connected to myelin formation. In several studies, iron deficiency early in development causes impaired myelination. With regard to myelination, we do have some new infant data. This is out of my work with colleagues in Chile where we have been doing studies in conjunction with an advanced neurophysiology laboratory. In using auditory-evoked potentials, normal development has shorter and shorter central conduction times over the first 18 to 24 months of life as the nerve conduction gets faster. For children identified with iron-deficiency anemia at six months of age, their central conduction time gets slower and longer. After a year of treatment, at 18 months of age, non-anemic children are approaching an adult level of four, as they should be, whereas for the anemic infants, the difference has become even more magnified after a year of treatment, and all of their anemia improved. With regard to central conduction time, this has been well worked out. The reason nerve conduction in the auditory pathway gets faster has to do with myelination of the auditory pathway. This is the closest we have got for human data: iron is doing something in the CNS, and one of the areas is myelination.

The other area that we are looking at is changes in vagal tone, which has to do with cardiovascular regulation. In developmental psychology right now, there has been a lot of interest in vagal tone as a measure of vulnerability to stress. What we are finding is that the anemic infants also have reduced variability of vagal tone, and that would place them more at risk, both developmentally and in stress responses. Again, we can postulate that it has to do with myelination, because myelination of the vagus nerve is partly postnatal in the human.

The second concept is actual behavior. In the first study in Guatemala, infants with iron-deficiency anemia were more wary or hesitant, more fearful. Others have found differences either in their unhappiness, fatiguability, or tension. In that larger study that I did in Costa Rica, we also

Health, Mental Health, and Resiliency

videotaped the children during the developmental testing. More of the anemic children remained wary throughout the motor test. They never engaged in it. The motor test can be fun, but they could not allow themselves to get comfortable in the situation. Bailey testing does not tell you much about children's ordinary lives, so we have also videotaped them in play with their mothers, both in Guatemala and in Costa Rica. The big difference that we found was how close or distant the mother/infant diad was—what proximal relations they maintained. For these toddlers, being far away from the mother is beyond arm's length. So we considered this close contact, within arm's length or touching, and distant, beyond. Part of development is using the mother as a secure base for exploration—going away from her, checking back to her, knowing it is okay, going a little further next time, coming back. Going away for a little longer time and coming back is the norm with a secure base. It is what you would like to see a baby or a toddler doing. What we found is that more of the anemic infants never go beyond arm's length. This is in a free-play setting where they are with their own mother, so this does not even have the stressfulness that a developmental test might have. Looking at a 15-minute play period or developmental testing still does not tell you about the children's daily experience. We also looked at their homes. In the study, we went into the home every day to give them medicine for three months. At the moment of entry, the psychologist recorded what was happening in the household. It was a spot observation. In the first week's data, the anemic infants were more likely to be carried by their moms, crying or playing alone, asleep, doing nothing, or eating alone. They were less likely to be observed doing interactive play or playing with siblings.

This constellation of things that we were talking about, the wary, hesitant behavior, and the increased proximity to the mother, led us to start thinking about iron-deficiency anemia in the context of functional isolation. This is a hypothesis that came out of generalized under-nutrition. It states the changes in affect or activity lead infants to seek and/or receive less stimulation from the physical and social environment. Over time, this would interfere with the baby's or young child's normal acquisition of environmental information. This functional isolation contributes to the poor social, emotional, mental, and motor development. This is a mechanism that gets into the environmental side of things. As a result of this hypothesis, in one of the studies that we are just completing in Chile, we have also included a family-based early intervention component. We are working on the mother/infant diad primarily, but also with other family members, to see if through added support we can counteract this early nutrient deficiency.

You would think that we have solved the problem, since we have these brain effects. Yet, the more sophisticated we get in looking at children's environments, we see environmental disadvantages, the confluence of biologic and environmental risk. In data from the Costa Rica study, the anemic infants were breast fed for a shorter period of time. They had mothers with lower I.Q. scores. They had lower home scores on the Bradley Caldwell measure of stimulation in the home. In some studies, you enter all of these variables, and the effects of iron-deficiency anemia are still statistically significant. In others, maybe they are not. However, I am convinced that the families are different. Whatever we can measure are only crude approximations of what the family environment really is like. I am sure that nutrient deficiencies go along with environmental disadvantage, and the children are not being reared in the same environments. If you begin with iron-deficiency anemia, you have decreased brain iron, hypomyelination and impaired dopaminergic function, delayed neuromaturation, and increased stress vulnerability going together to create that behavior pattern of increased wariness, increased proximity. On the environmental side, for whatever reasons, you have families making poor feeding decisions that contribute to the iron deficiency itself—in this case, less breast feeding, more cow's milk. You have more maternal depres-

sion. All of the disadvantages in the environment contribute to more limited parenting. In the transactional model, you get the child not seeking as much stimulation; the parenting limitations not providing as much—coming into the functional isolation; more limited support for child development; decreased provision of learning experiences; and then poorer outcomes.

You can see why programs like Head Start or Early Head Start might become especially important in this model. Even if you have a biologic risk, sometimes some added environmental experiences could compensate for those early biologic risks. Similarly, when you have a more disadvantaged family, they may be unable to provide that extra support that might help a child compensate for a biologic risk. For both reasons, one of the areas that is most promising in nutrient deficiencies is to consider intervention at the family and child level.

Question: This is really fine work and I appreciate it, but I question whether it applies to Head Start. In the Head Start health evaluation, we had four levels of iron stores measured in over 600 children. What we found was that we do not appear to have a deficiency of deep-level iron storage in the Head Start children.

Betsy Lozoff: The question is about the reduction of iron-deficiency anemia in the United States. You are absolutely right. This is again one of the really wonderful public health triumphs: looking at the improved iron status of young children and infants. We went from public health clinics having 20% to 25% iron-deficiency anemia, just like the rest of the world, to 3% on national averages. In addition to which, the age at most risk for iron-deficiency anemia is lower than the Head Start age period. The 6 to 24 month old is really the at-risk age for a couple of reasons. One is that babies have exhausted the iron they got from the mother at the end of pregnancy. They have rapid growth, more rapid than preschoolers. They do not have teeth, so their ability to eat solids that have iron in them are limited. Those factors combined put that late infant/toddler at the highest risk. Yet, within the United States, there are still risk groups for iron-deficiency anemia in infancy. The ones that I am aware of are in Latino populations. In some of the populations that do not have access to WIC but are really financially strapped, we are still seeing iron-deficiency anemia. At a population level, we have made a tremendous difference. I congratulate us all for that.

Ruth Etzel: We have here a confluence for poor children of poor nutritional environments and rich environmental hazards. The two combine in probably a more than additive way to have detrimental effects on children. I am also struck that we end up talking about each of these things separately. It strikes me that it is so hard for us to combine our knowledge and to work on it in a holistic fashion. Due to the way research is set up, we each have our tiny corner of the world. What we need to do is to try to determine how to get out of our boxes and use the knowledge from our own corners of the world in a way that affects the health of children in a substantial way. I do not have any answers, but I hope we can talk about ways of making that happen. What we tend to do too much is like the blind men; we each describe the part of the elephant that we see. It is hard to get a sense of what the whole elephant is really like and how we can best work together to achieve progress. We have to work together to modify not only the day care environment that the children live in, but the larger environment in which they find themselves, to look not just at iron, lead, and environmental tobacco smoke, but at ways in which they interact.

Some other researchers who have looked at the N-HANES, the large national nutritional survey, have found an inverse relationship between iron and lead. Of course, one of the strategies

Health, Mental Health, and Resiliency

that Peter did not go into in depth is nutritional strategies for lead poisoning. We did not talk about that, but there must be more ways that we can modify both the nutritional and environmental hazards that our children are exposed to. There are also plenty of other hazards for very young children in day care that we did not mention. We did not mention the very severe effects that other metals like mercury can have on the developmental status of children. Up until recently, mercury was in most paints in the United States. When we do studies, we do not look at the combination of lead and mercury in paint; we only look at them separately. It has continued to be a stressful problem to evaluate what the effects of both metals might be on very young children. Both problems are now supposedly solved, although we know that children in the developing world can still be exposed to paints with mercury and lead. We may have solved the problem in the United States, but not in the rest of the world.

There are other environmental contaminants that we have not talked about. One that is coming to our attention at CDC is the importance of mold in children's day care and home environments. Molds can be important in developmental delay and in neurologic development of children. We have just finished reviewing a study from home day cares in Seattle and found that over 40% of them had toxic molds in their day care environments. Additionally, after hearing Ben talk about the asthma problem and environmental tobacco smoke, I cannot help but think about the problems with dust mites, cockroach antigens, and such things that are in day care and home environments. The question is: Where do we spend our time and our money? I would like to engage you in a discussion of that because you know much better than I do about the money that is available and where we might get the most effect for that money. I would encourage us to think more holistically than we have in the past about nutritional and environmental factors so that we can avoid some of the problems of looking at individual aspects of the elephant.

Audience Questions and Comments

Question: It will be interesting after you have stressed the specificity in terms of deficiencies in interactive behavioral issues with the infants, to look at maternal depression. Did you collect any information on MDI or maternal stress?

Betsy Lozoff: Each time I do a study I find I am wanting to know more about the child, but also more about the family. So beginning with Costa Rica, we started getting data on maternal depression. For the Costa Rica study, we collected data on the mothers when the children were five years old. In the Chile studies, we are collecting it during infancy as well. A sobering thing is the proportion of women with depressive symptomatology—in the clinical range of about 40%. If you look at disadvantaged women in epidemiologic studies from the United Kingdom and the U.S., it is also that high. For child care workers and health care professionals, particularly in mothers of young children in stressed environments, think maternal depression. Now, I do not know the answer. I have not gotten to the point of being able to analyze the confluence of nutritional disadvantage and maternal depression, but I am sure that for child outcomes we should be thinking about maternal depression.

With regard to lead, there is one study from Yugoslavia that looked at both lead and iron-deficiency anemia. A lot of the earlier studies on lead did not look at iron. In that one study, they found both had effects. I am part of one of the studies that has found no effect of lead on development in Costa Rica or in Chile. The average lead level for Costa Rica was 10. The average lead level in Chile is in the five to seven range. In both studies, we only had one or two children above 19 or 20. We are only seeing children at the low end. With children only at the low end, we see no negative correlations ($r=.02$ to $.05$). That means a zero relationship between mental or motor development for five-year outcomes for Costa Rica. The issue comes up when you get results from homogeneous communities in a developing country that are different from what you get in highly industrial societies.

Question: What was your sample size?

Betsy Lozoff: For Guatemala we had 28 anemics and 40 non-anemics. In Costa Rica the sample has 191, with 52 children with iron-deficiency anemia. In the study in Chile, the neurophysiology work, the Ns are very small. Those are maximum 20 and 20, anemics and controls.

Peter Briss: I knew that you were involved in one of the studies that did not find an effect, and I tried to be fair about this when I summarized. Every study does not find an effect. One of the ones that I showed you (Cleveland) clearly had no effect by itself. However, when you look at all of the literature in total, the bulk of the studies are to the left of the line. So there are some studies that have different conclusions. It is important to look at this issue of effect modification. What is it that is different between studies and populations that may account for the different effects? To date, you would have to find a lot of negative studies to make the whole effect negative.

The second point is an important one that I am embarrassed that I did not bring up. There are many disadvantages that are associated with lead in the same way that they are associated with iron. It is usually true that children that are lead exposed are poorer than other children; have less stimulating home environments; and have mothers that have lower I.Q.s. The question is: How do we know that it is really the lead and not one of those other things that are associated with lead? We know that for a couple of reasons. One is that these confounders are very different across studies. Some of the studies that were done were in very disadvantaged populations in Cleveland and Cincinnati. Some of the studies were done with relatively advantaged children in Boston and Port Peary. If the epidemiological findings were about confounding, then you would expect that the lead effects would look bigger in the disadvantaged populations and smaller in the other populations. The real data is exactly the opposite, in that the bigger-effect sizes are in the more advantaged population. So the data argues against that. In addition, the animal data argues against that. You give some animals lead and you do not give other animals lead, so confounding is not an issue. The animal data looks like the human data. There is a good bit of evidence that suggests that this is not about confounding; it is about something real. When you look at the effects sizes that I showed, these are all after you adjust for all the confounding variables. It is true that some of the studies looked at iron and some of them did not, and every study cannot look at every confounder. Insofar as we can adjust for confounding, all the data that I presented already does that.

Health, Mental Health, and Resiliency

Question: Is there a place we can go and review the literature, because it sounds like a multifactorial-type situation here. You have interactions going beyond effects size. Can we find percent of total variance in these factors? When we look across the individual research, how does that fall out for total variance, and then which has the highest of the total variance?

Peter Briss: They may boot me out of the epidemiologists' union for saying this, but I could care less about the percent of variance. It is a meaningless statistic if nobody understands what it means. The other thing is that it is dependent upon the range of blood leads that you look at. If you are looking at people at the low end of the blood-lead scale, then you are not going to get much variance. If you look at children from 0 to 100 in blood lead, then you are going to get more of the variance, and this is just an artifact of the study. The effect size is clinically more meaningful, like points of I.Q. are much more meaningful than percent of variance, which is just a statistical artifact.

Question: One other question on serotonin that relates to that second portion. Is a lower serotonin level related to behavior?

Ruth Etzel: The question has to do with serotonin and the research on correlates with adult behavior. In the animal work for iron deficiency, the serotonin factor was significant in one investigator's lab particularly. I do not know how strong it is, whereas the dopamine system is quite well worked out. So I leave it as a question mark. With regard to serotonin and major depression, in the adult literature there has been an intense search for those correlates. To get back to the children and their iron deficiency, I have not found any way to get anywhere near serotonin in infants. It is just a blank.

Comment: Children in Head Start who have asthma and allergies seem to have double that of the normal population. For those that have been identified as "at risk" or as having special needs, it is double that again. It seems to be more of a contextual than an identifiable problem, which in our area, may be associated with hurricanes that seem to affect the environment to a considerable extent.

Ruth Etzel: People have never given mold much attention. There is a growing literature on the importance of dampness and molds in developing wheezing and asthma. Although no one has yet done an intervention trial to see whether or not ridding the home of the dampness problem reduces the chance that a child will develop asthma, it is plausible that that could be proven would it be tried. We should all be paying much more attention to the dampness and mold in our day care centers and our home environments, because asthma is becoming an epidemic among children in this country. We have not figured out a prevention strategy that will appropriately address that epidemic.

Ben Gitterman: Asthma is not decreasing. It is not only that it is becoming an epidemic, but it is not decreasing in this country, and that is probably the most relevant factor. We have new drugs, but hospitalizations are increasing. Although the length of hospital stay may be shorter, the numbers of hospitalizations are increasing for asthma. Mortality is increasing—something we do not talk about very often. Incidence of school absence has increased from asthma over the last 10 years. We are making some progress in smoking in this country. It is nowhere near the dramatic

public health improvements that we have had both with anemia and with lead, but we have gotten somewhere. Yet this condition is worse. Obviously there is more to it than just the things that we are aware of. Mold may be a very real contributor.

Health, Mental Health, and Resiliency

■ Community Child Health in the 1990s: Integrating Community Child Health, Part I

Chair: Jack Pascoe

Discussant: Mireille Kanda

Presenters: Judith Palfrey, Lindsey Grossman, Jeanne McBride, Suzanne Steinbach

Judith Palfrey: Last night I attended the City Year graduation in Boston. It was extraordinary to see how this program is working to teach young people about community, context, and health, and how hard it is for the young people to learn that little steps make the bigger picture. There was a story in the commencement address that I want to share with you. A person walked past two bricklayers. He asked the first, "What are you doing?" The bricklayer answered, "I am putting one brick on top of another, and smearing some stuff in between." Then he went to the next bricklayer and asked the same question. The second bricklayer said, "I am building a cathedral." That is what is happening here and across the country. These are the bits and pieces that we are trying to put together to build the cathedral and to make some sense of the world that our children live in.

We can divide the present century into three areas with regard to childhood morbidity. The first one we might consider classic. Before 1950 we were plagued by high rates of infectious diseases and high infant mortality rates. Children were dying of measles, rheumatic fever, and so forth. There was poor nutrition, not because people were eating potato chips but because people did not have food to eat. There were few cures for chronic illness. In fact, there was no understanding of the basics of chronic illness upon which to develop a cure. Tuberculosis, rheumatic fever, and other diseases spread because people were overcrowded. The influenza epidemic of 1918 killed more people than World War I. That was the first half of the century.

Then came the discovery of antibiotics. It is amazing to think that the first antibiotic was only available 50 years ago. Vaccines and even insulin for diabetes were discovered. Also, birth control made a profound difference. All of these things have shaped the next years in our history. People wondered what to look to next since infectious diseases were no longer a threat, and they began to think about family dysfunction, learning disabilities, and mental retardation. They also began to look at the educational needs of children. This was the halcyon time in child health—a time when we began to understand the whole child and to think about the larger needs.

From the 1980s on, just when we thought everything was under control, something happened. Epidemics are back. The epidemic of homelessness, the epidemic of AIDS, and maybe, based on some of the things we have heard, an epidemic of hopelessness. We also have a new group of children who have survived chronic illness. We need to be thinking about them. This gives us some new issues.

In a country as rich as ours, it is unfortunate to have an infant mortality rate around 19, to have immunization rates in the 40 to 50 range in some of our cities, and to have the emotional disorder rate as high as we do. The other issue is the differential between rich and poor children, and between African-American and White children, in terms of the kinds of health problems that they have. One of the issues for us is that in this country we do not have a child health policy. We do not have a way of addressing these issues. Health care is not a universal right in this country. Other countries cannot believe that we have 45 million uninsured people. We have a private system, a public system, and a non-system. That, of course, creates the uneven access, the crisis mentality, and the inadequate attention to prevention that we see. Yet, all is not bleak, because there are some new ways that people are thinking about children, prevention, and health care in

Health, Mental Health, and Resiliency

the context of their families. There are school-based clinics, early intervention, and immunization tracking systems. In addition, there is the work that you are doing in Head Start.

There is also the initiative called Bright Futures. Basically, Bright Futures is a codification of standards for disease prevention and health promotion. More than that, it is an attitude with three aspects. The first is that prevention works. The second is that families need to be integrally involved in the health care process, not as people who are told what to do, but as partners with whom we confer. And the third is that health care, prevention, and promotion are everyone's business. It belongs in Head Start; it belongs in day care; it belongs in schools.

Jeanne McBride: This is a presentation about the ABCD and Boston City Hospital Preschool Asthma Education Project. It is a collaboration between both of our facilities and is funded by the Health Tomorrows Partnership for Children, which is a maternal/child health and American Academy of Pediatrics group. ABCD is an antipoverty agency, the largest one in New England. We provide a variety of services to low-income residents in the City of Boston. Currently, the Head Start program within ABCD services 2,242 children, 109 of whom are infants and toddlers in a zero-to-three program. Boston has an ever-increasing immigrant population, with the largest number of Haitian residents in the United States outside of Miami. We also have many other diverse cultures. As a consequence, we have health issues related to those various groups. ABCD Head Start has 18 centers throughout the neighborhoods of Boston. Boston City Hospital is a publicly funded hospital located in central Boston, and they provide comprehensive acute and primary care services to mostly urban, low-income populations. This project grew out of an awareness of an increasing incidence in the severity of asthma in Boston, and particularly in Head Start. The national prevalence rate of asthma is around 5% to 7%, and in 1994-95, Head Start had an average rate of 12%, with a range as high as 22%. It increased significantly this current program year. Boston City Hospital found that families of preschool children were not able to assimilate asthma health education when at the hospital with the child in crisis. ABCD Head Start recognized the need for improving services to families of children with asthma. This led to a partnership between ABCD Head Start, the clinic, and the family. We view the team as including the children, the parents, the clinic nurses, the doctors, the Head Start family advocates, the health staff, and the teachers in the classroom. We envisioned the team helping families to learn about asthma, its causes, and treatment; sharing information with parent groups and staff; providing training for child play activities and improved communication between the various team members.

This is a five-year project. The first year explored the educational needs of parents and Head Start staff. Dr. Steinbach met with several groups of parents that represented the diversity of families in Head Start. We were surprised at some of the information that came out of those parent focus groups. We found that parents had a fair amount of information about asthma, but their concern was if Head Start staff would recognize when their child was having difficulty and be able to respond with appropriate care. That allowed us to modify our plans for intervention and to put in a strong communication link between Head Start staff and parents, children, and the clinician. In addition, that first year we sent out a survey to the area primary care providers working with children and asked them what they thought would be the best way to assist their patients. We also have an advisory committee comprised of parents from the Head Start program whose children have asthma, health care providers from the area, and representatives from some of the asthma support groups like the Asthma and Allergy Foundation. This committee has met on a period-

Health, Mental Health, and Resiliency

ic basis to look at our project, our forms, and our intervention strategies, and to give us feedback as to where we should go next.

The second year, which is this program year, started with a parent workshop. This was to provide basic asthma information and training. Dr. Steinbach and other support staff from Boston City Hospital came to the Head Start centers and provided the training on site. We provided assistance with child care and conducted the workshop in Spanish and provided translation in Cantonese to meet the needs of our diverse community. Part of the workshop format included hands-on materials for families to look at and explore. It was also an opportunity for parents to ask questions, to share their experiences, to network, and to create support groups with the other families within their community.

In addition to the presentation from Dr. Steinbach and other staff, we used a video called "Roxy to the Rescue" in English and Spanish. In this video there is a child of eight or nine and a teenager. The teenager is not taking care of his asthma appropriately and gets into trouble. The young child is a thorn in his side telling him that he needs to see the doctor and should take his medication. We thought that was a nice supplement to reinforce the information presented. To facilitate communication between parents and Head Start staff and give parents confidence about leaving their children, we developed a book called *Asthma and Me*. It describes a particular child, his family members, his favorite activities, what triggers his asthma, his symptoms, his medications, and his relaxation exercises.

Suzanne Steinbach: You have heard about the educational activities directed at parents and children. Next, we would like to present the activities we employed with Head Start staff to provide a foundation for enabling us to tell parents that staff were prepared for routine asthma care at school and for asthma emergencies. Asthma workshops were prepared separately for teachers and health staff. Teachers were invited both in this Head Start year and in the previous year to a three-hour workshop at the hospital. The facilitators included a pediatric asthma specialist, an asthma nurse, and an early childhood psychologist. It was a typical asthma education curriculum, with emphasis on little children and on the inner city. We talked about the epidemiology of asthma in Boston, how asthma works, the patho-physiology, the triggers to be expected in the inner-city home and school, medicines and how they work, expected side effects and how they are woven together into treatment plans, treating asthma episodes at school, a young child's developmental level and how that interfaces with chronic disease, and, finally, steps toward working with parents to control asthma.

We attempted to assess baseline knowledge and knowledge gained through this workshop by using a quiz modified from the National Institute of Health's Asthma I.Q. so that it was more specific to young children and the inner city. They attained 68% out of 100 score at baseline. Afterward, the scores increased on average, but only slightly. We saw significant improvement in understanding that asthma is the most common chronic disease of childhood and that children often do not outgrow asthma. These gains were outweighed by some real losses in areas such as understanding that children with asthma can play hard and that asthma absences are avoidable. We certainly thought we had dealt with those topics in the workshop, but we saw no positive gains in knowledge. Realizing that these were the outcomes of our first workshop, we distributed a thank-you note to all the teachers for their participation, and on the reverse side were what we considered to be the correct answers for their review. We then prepared for the subsequent year.

This year, teachers who were new to Head Start were invited to come to the same three-hour workshop with those improvements that we had added, and we found that scores increased

further from a good baseline level. There were positive gains in more areas and in areas that are important to actual Head Start teacher action, such as encouraging children to be active outdoors, knowing when to give medications at schools and their importance, and the fact that Head Start children help in recognizing triggers and in recognizing the need for medication.

We saw no decreases overall except in the area of warning signs. With an improved, refined workshop, outcomes also improved. Interestingly, when we distributed the same quiz to teachers who had remained on the staff, we found that without their hearing the workshop again, but simply by having received the correct answers the previous year and having had ongoing interaction with families and the Head Start managers, their scores had increased over the intervening year. They had shown significant increases in important areas: understanding the importance of warning signs, encouraging children to be active, and avoiding absences. The program itself appears to reinforce and increase asthma knowledge among teachers.

A separate program was prepared for the Head Start health managers. Again, there was a three-hour session spent together with a pediatric asthma doctor. We reviewed the same basic topics, but there was a greater emphasis on the actual action steps and areas for initiative open to the health manager. We talked about an asthma treatment plan and how to assess its appropriateness and adequacy in comparison to the child's asthma symptom level. We discussed steps toward working with parents and with clinicians to optimize asthma health. The health manager workshop outcomes were assessed by using a tool we developed to measure knowledge and awareness of action steps. We presented the health managers with six asthma scenarios and asked them what the health manager should do. We compared the number of appropriate responses submitted by the health managers to those of the sum total that we devised. Viewed in this way, the repertoire of positive action responses offered by health managers increased significantly on a wide scale in response to each of these situations.

Our conclusions from these educational undertakings are that there is considerable baseline asthma knowledge among Head Start health and teaching staff. Short workshops can expand on this knowledge base dramatically in the case of the health managers, and significantly in several areas with teaching staff. The opportunity that we had to fine-tune the teacher workshop based on observations in the first year made us able to increase its impact in the second year. We are now looking at the important outcomes—improved health status of those Head Start children with asthma. We are looking at rates of absenteeism and morbidity, such as emergency room utilization and hospitalization, and in succeeding years we should be able to tell you more about that.

Audience Questions and Comments

Question: How is this related to neighborhood revitalization? Have you identified or thought about using paraprofessionals living in neighborhoods to play some role in outreach and as contact persons? Also, what about funding? How does all of this connect to managed care? It seems like managed care should want to invest in this.

Suzanne Steinbach: One local HMO responded to our suggestion that they might want to support us, with the comment that they "only support direct health care." If we can succeed in showing some efficacy, and we have early indications that we may, perhaps we can attract the dollars. As it is, they are willing to share data with us. HMOs have databases, some of them with very rapid turnaround time. Several HMOs and Medicaid are willing to provide us with morbidity

Health, Mental Health, and Resiliency

information, hospitalization, and doctor visits for Head Start children if parents give us permission for release of that data.

The other question was about using community volunteers or staff to carry this asthma education message. There are many initiatives in our city right now regarding asthma, creating opportunities for collaboration with community agencies that are also tackling the asthma health challenge. ABCD Head Start has a family advocate on staff who has filled an important role gathering baseline data and communicating with families about school absence. Yet in terms of education, it still largely has been the teacher and the health manager.

Question: Was this a Head Start initiative when this started, and how did this come about?

Jeanne McBride: It actually was not a Head Start initiative alone. This was a joint initiative between Boston City and ABCD. We had a pilot study in 1991. At that point we were both seeing an increase in asthma, and City Hospital noted that while they tried to do asthma education when the child was in crisis, the parents were not able to take that information in. They were looking for a program where they could reach out and do asthma education. Head Start was a natural partner. On the Head Start side, we were also noticing an increase in children with asthma. We were noticing the excessive absenteeism. These children were not getting the benefit of the Head Start program if they were not there. When we talked with one another, it worked out that this was a natural marriage.

Lindsey Grossman: I would like to talk to you about observations I have made over my 20-plus years as a pediatrician interested in community issues. People often ask me to explain community pediatrics. I cringe when they do because it is difficult to describe. One of the reasons it may be difficult to describe is that it is difficult to put a fence around something that is so large. I want to talk to you today about how pediatricians can work with Head Start professionals. We are similar, and we can emphasize the positive effects by working together.

If you ask people what a pediatrician is, as opposed to what community pediatrics is, you would probably get some pretty definite answers, since most people in this country have encountered someone with a background such as myself. Children get sick, and they need to see pediatricians. Illness care is something that pediatricians do. We do it in lots of places. Usually we do it in a clinic or an office setting. Most people will also tell you that pediatricians worry about well child care. Immunization has been one of our major mechanisms in fighting infectious disease and getting us to the point where we do not see as many children dying as we did several generations ago. We worry about hearing and vision because these are problems, which, if found early, we know can be impacted. They can be improved, not necessarily by pediatricians themselves, but by referral to appropriate agencies or other professionals. Anemia and lead poisoning are problems that fit significantly within the realm of medicine. Unfortunately, they are still around, although much less common. As a result, we need to screen for them. There is also developmental screening. It is looking for indications as early as possible that a child may not have the abilities expected at their age level, or may have the potential for having more problems later on. Again, we may not impact on them through interventions, but we can hopefully put the family in touch with someone who will. Anticipatory guidance is a term that many people are not familiar with in pediatrics. This is basically our opportunity to assist families in understanding their chil-

dren—where they are now and where they are going. In that way, they can best be in a position to assist their child.

Pediatricians also view children in a textual format in that we try to focus on the child's normalness. If a child is not fully normal, in whatever way that is described, we try to determine how to help the child become normalized as much as possible. Whereas the internist might treat you for diabetes to help you prevent further progression of the disease, a pediatrician will do all that for your child with diabetes while trying to figure out how to help the family and the community minimize the negative impact on that child's normal developmental processes. To do this, we try to promote the health of the child, and we define health broadly. First of all, the child's health has to be child-focused. Every child is a unique individual. Whatever we do and whatever we recommend for a child must be focused on that individual child. Whatever we do or suggest has to be family centered because no child exists without a family. It may not be the family of their origin; it may not be the most ideal family, but the child exists in the context of the family. Therefore, to be able to help the child, we have to keep that in mind. The family does not exist in isolation; it exists in a community. Any interventions or assistance that we suggest for the families and the children must take into consideration the community in which they live.

The schools, including Head Start programs, view my role in four categories. First, they know that I deal with symptoms. They want to know how those symptoms might impact the child. Second, what is the risk of spreading infections between children? Third, there are requests for specific medical treatment. Of course, it is more often vitamin R, as we refer to it in my clinic—Ritalin—than anything else. Fourth, what is the need for special care during school hours? How can we assist this child with special needs, chronic illness, or a disabling condition to be able to function best in our environment?

I would suggest to you that there are other areas that pediatricians could potentially collaborate with you and your programs on a day-to-day basis. First of all, we both focus on growth and development of the child. We can bring different perspectives, which hopefully can emphasize and make effective interventions that we want to try. Second, our orientation to preventive health and health promotion is to optimize the child's normalcy. We can and would like to be helpful to Head Start programs in doing that. Third, in the situation where the pediatrician has known the child and family since the child was born, we have an advantage and an insight into how families are adapting to and handling issues. There is a way that you could help us. If children are going to Head Start and are not coming to see their doctor or their nurse practitioner, a reminder can be helpful to the family and to the overall ability to positively impact on that child, particularly around their health care.

Pediatricians are trained in differential diagnosis. We look at all the possible things that could have caused a situation, and then we narrow them down by ruling each one out. It is a way of thinking that helps to take into account potential external contributing factors, while still focusing on the individual. We emphasize the importance of individual variation and specific issues of the individual child. We also take into consideration the effect of chronic illness. Previously, the child and family were left to their own devices. That is not the case now. We all want to figure out how these issues of chronic illness are impacting the child and how their effects can be minimized. And there is the issue of social and emotional stress. These, again, are family issues because we recognize the importance of viewing the child in the context of the family. As pediatricians, we are used to dealing with compliance issues. It is surprising how often people working with children do not realize that what you recommend to a family or to a teacher is often not done.

Health, Mental Health, and Resiliency

Many of the objectives that you are well acquainted with in your programs are very much in line with those of pediatricians. We are concerned about early education for the socially disadvantaged, because, as pediatricians, we are worried about the child's overall development. Head Start has always been a community-based organization. Medicine has not always been a community-based organization, and it needs to be.

The Head Start program requires anemia screening, lead screening, sickle cell screening, visual, dental, hearing screening, and developmental monitoring. These are all things that we are glad that you do. There is also dental care and nutrition. Certainly we all know of children who get one or two good square meals because they go to a school program that has nutrition. Speech and language evaluation through Head Start has meant that many children have gotten help who would not have otherwise.

Special education has been something that pediatricians have been interested and involved in. With the combination of our advocacy and our role of making certain that children who ought to be in special education and early intervention programs are getting identified and found, it has been a successful one for children. P.L. 99.457 certainly updated and took us one step further in that it paid attention to the fact that if we could detect problems earlier, before age five, we could do more to help these children. It gave us a chance to be able to find services for children at risk. As a pediatrician, I view my role as a collaborator with you in finding these children and getting them into programs. Additionally, pediatricians are probably less involved in developing Individual Family Service Plans than they should be. Call on your local pediatrician. They may be able to give you some help. They will certainly profit from the opportunity to work with you.

Last, but certainly not least, we are concerned with the chronically ill child. We have only begun to scratch the surface on where we could and should collaborate. Asthma is probably one problem that is starting to get a lot of attention because there are an increasing number of children with significant and expensive health problems. Children are also dying from asthma at increased rates. It is clearly the most common chronic illness, but there are many other chronic conditions that are very common. There are developmental disabilities, cerebral palsy, seizures, and so forth. Each of these diseases, if left untreated, is likely to become a disability, and that disability would become a handicap. However, as a pediatrician, I have an enhanced role in coordinating services to promote the child's optimal health and development. In almost all cases, the handicap can be prevented by hitting it at the disability level. And the disability can be impacted best by hitting it at the disease level. We need to remember that there is a child there, a normal child underneath. We need to determine how to help that child deal with their disease so that it does not become a more negatively impacting problem.

Audience Questions and Comments

Question: Collaboration is a great idea, but there are pediatricians who are more inclined not to do this. I am wondering if in the American Academy, they are doing anything to encourage community collaboration, or if you can suggest strategies for engaging pediatricians to work better in the program?

Lindsey Grossman: Yes, there are a number of initiatives that the American Academy of Pediatrics has undertaken. The Academy includes over 50,000 pediatricians. The vast majority of people who are board eligible, who have had three years of training in pediatrics, belong to this

organization. That is a much higher percentage than almost any other physicians' professional organization. There is a good reason for it. We are not a labor union for doctors, like some organizations. We are a group of people who are concerned about children. For many of the 50,000 doctors, the only thing they are doing for children in the community is sending in their dues every year. However, the Academy then takes that money and does some marvelous things with it. One is called the Medical Home Project, which is directed at children with chronic illness. Another is emphasizing the need to have a coordinating entity for that child's services and the appropriateness of the pediatrician as that coordinating entity. The Section in Community Pediatrics and the Committee on Community Health Services that I am on are also involved. Much of the educational program has to do with how pediatricians can and should be working in the community, and how they find community contexts to be able to work with them.

Relative to your other question of strategies, there are many, and basically I go with strategies that work. If you get a call from a pediatrician about something, that means that pediatrician has already stuck his or her head above the crowd. Make sure you get that doctor's name, phone number, and address. You might call on him or her the next time you need someone on your advisory board or you have a question about a child or a policy issue. You might also ask if he or she knows someone else to recommend. Keep his or her name. He or she called you or responded to your call, and that indicated interest. Doctors tend to be in the community for a long time, and, unfortunately, people such as myself who educate residents do not do the greatest of jobs. We do not have them for that long a period of time. People who have been trained in most recent years are probably feeling more comfortable in dealing with community-based issues than those who may have been in the community for longer periods of time. If you cannot get anybody to answer your calls, try calling the State Chapter of the American Academy of Pediatrics. Another resource is your State Department or Division of Maternal and Child Health or a Department of Pediatrics at a nearby medical school.

Mireille Kanda: I am gratified and almost amazed at the commonalities of philosophy in what we have heard this morning and what the philosophy of the Head Start Bureau is. Dr. Palfrey certainly set the stage for us in taking us through a voyage of looking at what has happened to the health of children in this century and pointing out to us the issues that are of greatest concern to us now. Although we have conquered a number of infectious diseases, or communicable diseases, that were wreaking havoc among our children in the past, those challenges are not completely gone. The price of success is that we have to maintain eternal vigilance. The issue of immunization certainly speaks to that. If we give up on immunizations or if we become complacent about them, it does not take long for us to see the results. The measles epidemics of 1989 exemplifies that. It is incumbent on all of us who care for children to make sure that we continue our work and that we continue to exhort parents and assist them in keeping their children fully immunized.

I was delighted to hear more about Bright Futures. It is important that we look at the health of children in a very broad context. In fact, as we look at health, we need to remain aware of issues of nutrition, dental services, and mental health services. In talking about community pediatrics, it is important that we look at the issue of involvement of practitioners in the community per se, going beyond the four walls of the office. A wonderful illustration was the asthma program. As we see health education progressing and how it touches both the caretakers for the children and the families, we see that knowledge can be augmented and that changes can be made. We are looking forward to the results that you will have in terms of the outcome measures.

Health, Mental Health, and Resiliency

I would like to now shift to Head Start and how we bring all these things together. People still think of Head Start as primarily an educational program. Indeed, it is a strong early intervention program, but it also includes health. My colleagues and I in the health branch are working on developing and strengthening a strong health presence within the Bureau. We look at health in terms of individual advocacy for children as being extremely important and going beyond mere compliance with performance standards. We want to have more than numbers on our PIRs for various programs, because we are looking at the health of children. We also want to look at each child as being unique and precious and go beyond the calculations of how many children have lice, and how we eradicate lice as a group problem. It is also important to point out that we are in pursuit of quality. We do not want minimal health services for children; we are looking at optimal health services for children. And finally, let me echo the thread that has been present in all the other presentations here, the issue of partnership building. Our report for quality in the work of 21st-century Head Start is grounded on the issue of quality and partnership building that has to occur on multiple levels. We can see it as many circles that overlap each other, as a dynamic multidimensional construct where all the pieces work together. Each piece is so important that it has to work in order for the whole to continue to function. We look at partnership between the program practitioners, the families, the health care providers in the community, the Bureau, and the various parts of the community. How do those issues fit together when we look at the barriers to health care delivery, the issues of liability? How do we make all those constraints work together? It is a challenge for all of us, but one that we can address together.

Audience Questions and Comments

Mireille Kanda: Let me mention to you that the early childhood community of the Academy of Pediatrics is currently starting to look at the idea of developing a curriculum to get pediatricians oriented and to urge them to serve as consultants to Head Start programs.

Judith Palfrey: In terms of the educational aspect of this, the book *Bright Futures* has been sent to every pediatric intern in the United States, so that they will be exposed to the idea of moving care into the community. We are hoping that you will find more receptivity as we conduct these educational efforts.

Question: After 20 years of working in Head Start, I find that many of the health staff have spent a lot of time finding other resources to do things that they hoped the pediatrician would do, such as vision, hearing and blood pressure screening. I work with a research access project in New York City for Region II, and one of the issues we face is how to get medical care for severely medically involved children included in Head Start programs. The local education agencies often do not see it as an education issue, and, therefore, the funding is not available. Are there sources of funding so that these children can be included in Head Start programs?

Jeanne McBride: Through Part H the children are eligible for services. The issue is paying for the special component. Our concern has always been that these services be provided safely and by the appropriate people.

Comment: The role that the Head Start can play is reviewing with families whether they have a source of primary care, a medical home, or a pediatrician. Some years ago when we did the Brookline Early Education Project, we were able to identify a number of people who did not have primary care providers. We worked hard, and by the end of the project, 99% of them had a provider. We felt that was the role of the Early Education Program vis-a-vis primary care. There are certain services that the family must have access to.

Jeanne McBride: That should be emphasized with Head Start programs in terms of quality rather than minimum standards. In Boston, our minimum standard is that every child leaves the program with health insurance. We are fortunate in Massachusetts to have a safety net. Every family has a primary care provider that they know, and they know how to call and make an appointment. Those are our program goals for a minimum of health education. That should be something all Head Starts do for their families.

Health, Mental Health, and Resiliency

■ Community Child Health in the 1990s: Head Start & Managed Care—The Minnesota Experience, Part II

Co-Chairs: Jack Pascoe, Charles Oberg

Discussant: Mireille Kanda

Presenters: Charles Oberg, Nancy Feldman, Bryan Nelson

Charles Oberg: We are having this discussion today because there is a convergence of three ongoing trends: 1) the increased impoverishment of our children; 2) Medicaid's transition to managed care; and 3) the expansion and recognition of Head Start. If you took any one of those three out of the equation, we probably would not be having this discussion today. I am going to spend a few minutes on each one of these items and set the stage for a more in-depth discussion of the issue. The 1994 Census Bureau statistics show that a single person who lives in poverty in the United States has an annual income of less than \$7,547. For a family of four, this amount is \$15,000. Therefore, in 1994 there were 38.1 million people below the poverty line. For children under 18, there were 15.3 million poor; 22% of all children and 40% of all low-income people. In addition to the numbers increasing, there is a deepening of impoverishment. A 1985 report, called "Hunger In America: The Growing Epidemic," from the Physicians Task Force on Hunger at Harvard University, found that in America there were about 20 million persons who were hungry with about one-half million malnourished children. A follow-up survey two or three years ago showed that the numbers had actually increased to 30 million hungry persons in this country. In Minnesota, in the heart of the bread basket, over one million persons had used food pantries in 1992. Two thirds of those were families with children. Families with children, single women, and teenagers now make up the majority of homeless persons in this country.

Head Start is one of the few discretionary programs that is actually experiencing some increases. We survived the first session of the 104th Congress. Today, Head Start has about 750,000 children being served and an annual budget of about \$3 billion. There is a vast array of services and programs, both discretionary and demonstration, serving the same population of poor children as Medicaid. By necessity, we need to start coordinating services. It is my understanding that part of the Performance Standards for Head Start calls for providing families with the skills and techniques to make linkages to comprehensive health services. As health services move into managed care, we are going to have to learn how to deal with that new system.

We have had a significant decade of expansion from 1984 to 1993 as it relates to Medicaid eligibility for low-income families, women, and children. That was driven partly by some eligibility expansions from the Deficit Reduction Act (DEFRA, 1984) and was where we started to incrementally increase Medicaid expansion. The Omnibus Budget Reconciliation Act (ORBA, 1993) was another Medicaid expansion. What we gradually did was decouple Medicaid eligibility from AFDC eligibility, or welfare. We had a significant increase in the number of persons who were actually receiving Medicaid benefits. In Minnesota and in some other states, pregnant women and infants can receive Medicaid with an income up to 275% of the federal poverty level. The other thing that is happening is the continued erosion of employer-based dependent coverage. We think of this country's health insurance programs as built on an employer-based foundation, but less than 60% of Americans now get their health care through an employment-based plan. That foundation is made of sand, and it is continuing to erode.

As a result of the Medicaid expansion, states and the federal government have moved into the area of managed care. Driven by increased costs and eligibility expansions, Medicaid has about 36 million recipients. Eighteen million of those are children under age 21. They now represent more than 50% of persons on Medicaid. The U.S. spent \$156 billion for Medicaid in 1995

and \$3.5 billion for Head Start. By the year 2002, we are probably going to spend \$292 billion on Medicaid. We have increasing enrollment in managed care, presumably to do two things: improve quality and control costs. There are two types of waivers. One is a freedom-of-choice waiver, which provides the state the opportunity to limit freedom of choice and actually move people mandatorily into managed care plans. The other type is called Session 1115 demonstration waivers, and these are much more expansive. These tend to be five years in duration and add a more analytic and valiative component to the program because they are allowed to make some major changes to their state Medicaid plans. Right now about 42 states have Medicaid waivers, and 30% of Medicaid enrollees are in one form of managed care or another. In 1985, there were only about 500,000 persons on Medicaid and managed care in 20 states. There has been a significant explosion in the use of Medicaid waivers and Medicaid managed care to control costs and presumably improve the quality of care for certain communities.

Bryan Nelson: I believe that Head Start is a managed care program. We at Parents in Community Action Head Start serve Hennepin County in Minnesota, in the Minneapolis metropolitan area. It has a population of about one million in the city, and then two and one-half million in the metro area. We are expecting an increase over the next 10 to 25 years of one-half million people. PICA provides a variety of services. We have collaborations with public schools where school teachers are working in the classrooms. We have dental services on site. We have a Parent/Child Center Plus Program (PCC). We have a homeless program. We also have licensed psychologists and physicians serving on our Health Advisory Board. We have been in operation since 1969. We are the largest Head Start in the state of Minnesota, with 2,200 children. We have a variety of funding sources that enable us to have wraparound services: state, public school, referendum, and federal. Our mission is to provide services, support parents, promote community change, and develop partnerships. In our partnerships, we include the public, private, and corporate sectors. It cannot be done only with federal funds.

I have an intra-agency agreement between Head Start and the Health Care Finance Authority (HCFA). As you might know, Head Start is the largest health screener in the U.S. Our particular Head Start is focusing on screening. We do not do anything invasive. That became important to the physicians that we were talking to. We do vision, hearing, height, weight, and developmental screenings. We do nutrition assessments, daily health checks, and mental health assessments. We are an Early Periodic Screening provider and are able to bill for that directly with the state.

Supporting the fact that Head Start is managed care, we also do case management. All of our children are seen by our staff; our drivers pick up the child in the morning and look the child over and decide whether the child is ill. When the child is ill, we will connect them to a provider in the community. Eventually we get a chance to screen all our children because they are a captive audience. We think that Head Start is an excellent place to do screening and then refer the children to a primary care provider. The whole focus is to support the parent and empower them to select the provider that they need.

The last piece is partnerships with health care and mental health. Many of our families do not trust the mental health system. We have a licensed psychologist with whom we have worked for years, and the families have built a relationship with him. We are able to do an assessment or a screening and refer the family to the appropriate program.

Health, Mental Health, and Resiliency

Audience Questions and Comments

Question: There were three managed care plans providing services to the Medicaid population within Hennepin County, the entire universe of Medicaid managed care at the time. How did they differ?

Bryan Nelson: They were just different plans. In Minnesota, anybody could apply to become a managed care plan, Prepaid Medical Assistance Plan (PMAP). Three organizations did. You could either choose your plan, or, if you did not, you would default, and the state chose in a random pattern.

The law says that Medicaid has to provide EPS. However, I do not think a majority of clinics do a complete developmental screening as well as Head Start can do it. I do not think they do vision screenings. We conduct good audiometric screenings. It is cost-effective to do at Head Start. The children are there, and the parents are there to educate and work with. It may not make sense to use clinic dollars when Head Start can do it. We are supposed to make sure the children get screenings and examinations, but without using Head Start dollars. The contract says to use community resources to get your screenings done.

Comment: As a health care provider myself, the health care provider needs to be involved optimally in preventive health care and curative health care. What you are proposing is a little bit dangerous. If some of the patients are contracted as such and some are not, simply because they do have the benefit of belonging to a Head Start program, then the whole process for accountability becomes more complicated. We have enough problems with accounting for health care to the underserved without creating an additional provider of services that is not traditionally regarded as accountable. From the other perspective, that fragments the understanding of the health care provider in terms of his global vision of the health care of his client. If he says that he did not do this, whether in fact this information is present on his record or not, then it becomes your responsibility. If it is not, you may say that you never received that information, that you did not do that screening. The issue becomes: Where is the line that separates health care provision from other forms of support systems?

Answer: The main and unique function of Head Start that no health care provider can assume is the ability to empower and enlighten and improve the insight of the family into the necessity of seeking preventive health care. That is something that will stay with the family beyond their affiliation with Head Start. The point is to understand how important it is to get primary health care and to get it on time.

Nancy Feldman: UCare Minnesota is an HMO that was started by a department of the University of Minnesota Medical School. Currently, we have about 140 residents who are having a learning experience through a number of clinics that are run by the medical school. When Medicaid managed care came into the state in the mid-1980s, the University Family Practice clinics depended to a great extent on Medicaid patients for their care and services. The fear was that if these patients went into managed care plans that did not contract with the Family Practice Clinics, there would be no place for those residents to do their practical residency training. So in the mid-1980s, they started their own HMO. In the beginning it was aimed at those six or seven

Health, Mental Health, and Resiliency

affiliated Family Practice Clinics. Since then, UCare has grown quite a bit. Our mission, aimed at low-income people, is to improve the health of our members through innovative services and partnerships across communities. What makes UCare unique as a plan has to do with partnerships. We try to work with others rather than owning or creating or buying ourselves. Having that attitude helps explain our interest in working with Head Start.

We currently have close to 50,000 members. Minnesota's program for the uninsured, called Minnesota Care, is folding over into managed care, and we will be starting with that working poor population on July 1st. We had close to \$90 million in revenue in 1995. We are the fourth-largest HMO in the State of Minnesota. We are a network model HMO. We have currently about 150 primary care clinics that we contract with, and 7,200 total providers. We have subcontracts and subcapitation for behavioral health, dental, and chiropractic care.

We have learned through the years that low-income members have some special needs and special issues. Most issues are not that different from middle-class, or, in the managed care world, what are called commercial members. However, low-income members sometimes have special needs for education, for explanation of how the health plan works. Twenty-four hour access to care is extremely important for this population. Staff have to be sensitive to member needs. Some of the issues and concerns that our members raise when they call in or when they are trying to learn how to use our system are definitely different than what we have for a commercial population. Our members tend to need more support than most physicians' offices can or are willing or able to provide. Our members have many intertwined social and medical health care issues. For example, if a pregnant 16 year old does not have a place to live, and the housing issue is not addressed, she very likely is going to have health care issues that will end up being our problem. There are access problems that are not always found in the middle-class population. We learned early on that the health care system was designed for a population that knows how to speak English, has a car, and is able to get to appointments on time. We do a lot of primary care case management that is fairly supportive to the members. We think it is important for there to be providers available in a number of places.

We try to emphasize preventive services and provide a lot of education for our members. We have an incentive program. We try to support community initiatives and coordinate with existing community resources. We provide free rides to health, mental health, and dental appointments. We provide child care at some of our clinics so that members can come and bring their children and not have that be a disruptive experience. We spend \$500,000 a year contracting with Family Service of St. Paul to provide on-site social service advocates in clinics so that they can link our members who have social service needs back to the system. We work with Pillsbury Neighborhood Services and other community services to put on classes in cooking, parenting, violence prevention, and smoking cessation. Those issues are important to our members. We give gift certificates after the classes are over and provide transportation. We have incentive programs for pregnant women to go for prenatal care and for parents to bring their children in for immunizations. We have shown some documented increases in the number of prenatal visits that women go for, and in the percent of two year olds who are fully immunized in our control program over the regular program. We give a five-dollar gift certificate at some of our big food stores for selected healthy foods and every time a woman comes in for a prenatal visit or a parent brings a child in for an immunization. After the woman has the baby and comes in for her six-week postnatal check up, we also give her a \$75 gift certificate.

Another important factor in Minnesota is that we are the only state in the country with a nonprofit HMO law. For-profit HMOs may not operate in the state, and that has made a profound

Health, Mental Health, and Resiliency

difference. Our HMOs are home-grown plans that tend to have some pride and some connection back to the community, which smart groups can figure out how to use as leverage. Our health care sector has heavy health plan competition, but also many cooperative efforts. The HMOs tend to work together on issues like community programs and services. Working with Head Start helps a health plan put their prevention theory into practice and provides a powerful selling point for a health plan. Head Start has the ability to provide complete screenings. In addition, Head Start has an excellent reputation with the community in the twin cities.

Our experience shows that cooperative relationships can be very beneficial to the children who are involved. We may have more in common than at first appears. If you focus on the children, that helps to eliminate frustration with the system. If you are interested in this, Head Start will likely have to be the instigator and the main sales people. It would be unlikely that a health plan would realize that they do not have a contract with Head Start. You may have allies in managed care, or be able to form those allies, and not even be aware of it. They are out there if you can make those connections.

Audience Questions and Comments

Question: What percent of your total budget are you spending on social support services, parenting education classes, the violence-prevention classes?

Nancy Feldman: If we are talking \$90 million in revenue, all of those together probably would be \$700,000.

Question: You mentioned that one of your services was supportive case management. Could you define for us what you meant by that? How is it being delivered? Do you reimburse your providers on a fee-for-service basis for that, or is it part of your capitated rate?

Nancy Feldman: Both. We reimburse providers a fixed amount every month for each member. Right now it is three dollars per member per month for case management. We also capitate more of our larger primary care providers so they also have that incentive. Some of our bigger providers, community clinics, especially, do fairly well under that capitation system. You also need to remember that we are run by primary care physicians who tend to have a strong prejudice on the side of primary care.

Question: Have you educated, informed, and received consent from the parents for the things that you are now going to do in lieu of what was not done by the primary providers and the primary care clinics?

Nancy Feldman: We certainly have a strong education component for families. We have a newsletter that goes to members. We created a 16-minute video that explains to the families how to use managed care and why preventive health care is important. That is an ongoing process.

Mireille Kanda: This is a most fascinating and challenging discussion. Dr. Oberg set the stage for the issue: 1) there is a large number of low-income families who are not receiving appropriate medical care and who are uninsured; 2) the health care of these families is being viewed by the

states who provide Medicaid to them as an increasing burden that is getting out of control; and 3) one of the ways to deal with that issue is to look toward managed care, a vehicle for providing health care to populations.

When we look at this in the best of worlds, Head Start is managed care in a manner of speaking, especially when we look at the Performance Standards and the mission of Head Start: to insure that the children receive the services that they are eligible to receive. But going beyond that, Head Start is not obligated to pay for the services. Head Start dollars are dollars of last resort. They can only be used after there has been justification that efforts have been made to marshal community resources to pay for the services. There are programs that elect to become providers themselves; one model has been presented here. This model has advantages when it works well. In other places people have raised issues about programs that are working less than optimally in managed care. There are issues having to do with the continuity of care. When assignments change, there are families who may have been engaged with a provider for a period of time who find themselves reassigned to another provider. Sometimes a family with several children will be assigned to different providers located in different areas of the community. That may lead to a discontinuity of care for these families. And although managed care is supposed to enhance access, this is not always necessarily so.

There is also the issue of quality of care. Sometimes in managed care it is almost as if there is an incentive to provide less care in order to enhance cost containment and benefits. The process of provision of health care to Head Start children is a challenge that is evolving. This is something that we begin to see as waivers are granted and creative solutions are applied in different communities. There is going to be an uneven picture. I would like to go back to the mission of Head Start, which is to make sure that children get the comprehensive care that they need and that families be educated so that they are aware of the realities of what they are dealing with.

Comment: I would like to address the one theoretical policy issue that has come up, whether the preventive care and screening be done by the primary care provider or by Head Start. I am going to speak as a primary care provider and general pediatrician. I work at Hennepin County Medical Center as a pediatrician, and one of the plans actually uses Hennepin. We have worked closely with Head Start, and when they brought information to us that demonstrated that we were doing an inadequate job with some of the screenings, we did two things. First, we contracted with Head Start to make sure that the children in the Head Start system were, in fact, getting those services that they were entitled or eligible for, and second, we took that information to start changing and recrafting how we delivered care ourselves. I believe that we are doing a better job today than we were in 1990 and 1991. We have recrafted how we deliver services from some of the experiences that we learned from Head Start. It really is a partnership, and the children are the ones who have benefited from that collaborative effort.

Comment: I question who should be doing what. Do we teach a nurse practitioner, a nurse, or a health associate to do certain things as well as physicians? Where is this best delivered? If there are services available in schools or Head Start sites outside of offices, by all means take advantage of them. However, recognize that you then have communication challenges.

Bryan Nelson: What Head Start does very well is screen children, because we have children in context. We know what their baseline is. Every day the child comes in, we see the child, we know what is "normal" for that child. Some physicians do a very good job, but we have to admit

Health, Mental Health, and Resiliency

where it is not working in the medical community. Head Start staff are competent, and if they do not have credentials, it does not minimize their ability to evaluate or know when a child has something wrong. I train my staff to know clearly that if something is wrong, the child needs to be referred to a primary provider, and staff must work with the parent to explain what is going on. You remind the parents that they have a right to good services.

Mireille Kanda: I would like to remind everyone that Head Start programs have to have a Health Service Advisory Committee whose responsibility is to develop a health plan. The Health Service Advisory Committee must have input from health care practitioners in the locality. Flexibility is essential, as there are different-sized programs. For example, it may not be cost-effective for a small program to have an elaborate system of trained individuals to do certain activities. People who do activities have to be trained, have to be supervised, and have to be monitored in the performance of those duties.

Question: I have a rudimentary question. Who does the screenings?

Bryan Nelson: We have a variety of people doing screenings. Teachers do the developmental screening using a preschool screening instrument standardized for the children in the public schools of Minneapolis. Vision and hearing screenings are done by a group of people who are trained by the Society for Prevention of Blindness and Preservation of Hearing. We have interpreters who explain what is going on and work with the parents to get them to their primary provider. We have a county program that works with us to set up programs to talk with parents about food. We make sure the parents are in the WIC program if they have infants and toddlers. This is not meant to replace what a provider does. The thing that we do is educate the family about the health care system, letting them know what resources are available.

Question: How are you evaluating the effectiveness of what you are doing? How are you setting up the studies inside the organization? Who does that? Is it internal or do you hire consultants to come in and do that for you?

Nancy Feldman: That is one of the toughest challenges for health plans. UCare is in a fortunate position because our Board of Directors is composed 60% of faculty from the Department of Family Practice at the University, many of whom are researchers, and 40% of actual recipients of Medicaid and general assistance who are on our health plan. This makes for an interesting dynamic. They are able to use our capabilities as part of their research projects. Where it becomes a challenge is to keep it from being too academically focused. A health plan has to have the answer to the question, "Should we continue to do this next year?" We are able to look at, for example, the immunization incentive program in a way that provides answers that tell whether a program is one we want to continue. At the same time, we get some results that may be used by the academics in their practice.

Bryan Nelson: The model you are hearing about today is how it looks in 1995. It did not look this encouraging back in 1985 when we began. There has been a movement of public health professionals from the public sector into the private sector plans. We have more and more persons with public health expertise in every one of the plans in the twin cities now. They bring that expertise so that there is a much better understanding of why these other issues need to be

Health, Mental Health, and Resiliency

addressed. That was one of the unintended consequences of the move towards Medicaid managed care, a blending of the public and private sector that 10 years later has worked better than many of us providers ever would have anticipated.

Question: How do you help parents make the choice of a plan?

Bryan Nelson: We work with our parents and provide them with information about what the options are and then let them choose. We do not tell them we prefer particular plans.

Health, Mental Health, and Resiliency

■ Health and Safety in Head Start

Chair: Albert Chang

Discussant: Sheryl E. Anderson

Presenters: Albert Chang, Sandra Holmes, Margaret Brennan, John Fieberg, Rosemary Barber-Madden

The increasing enrollment of young children in Head Start and other out-of-home childcare programs has raised concern for the potential of infectious disease and injuries in these settings. The first presentation described data from one of the largest (171 child care programs) and longest (20 months) surveillance programs. The program found that the number of illness episodes decreases as the age of children increases, but after the age of two, more illnesses occur in the family child care home setting. The program also found that there are more absence days due to illness recorded in child care centers, but more medical visits are recorded for children in family child care homes. Children have the lowest rate of first-aid attended injuries in large family child care homes, but the rate of medically attended injuries is approximately the same, at six injury episodes in 100 children per year.

The second presentation summarized a study that compared the incidence of injuries (both minor and severe) in children who are in child care settings to incidence of injury to those in their own homes. The study concluded that there were more minor injuries in child care settings, but no difference in rate of severe injuries between the two settings.

The third presentation described a survey that found that many parents and caregivers misunderstand the modes of transmission of HIV infections. Since one mode of transmission is through blood contact with an infected individual, and many episodes of bleeding (following injury episodes) occur, educational strategies should be developed to provide accurate information and assure appropriate safe management of bleeding episodes.

The fourth presentation reported on the needs assessment of 220 Head Start programs in Region (DHHS) II (New York, New Jersey, Puerto Rico, and U.S. Virgin Islands). A regional health institute provided 350 health coordinators the opportunity to 1) share knowledge on current health topics, and 2) review results of the regional health needs assessment and develop strategies for future child health promotion activities. Epidemiologic research, survey of health information needs of parents and caregivers, and needs assessment of current child care programs are all needed for promoting the health and safety of young children in child care settings.

The Incidence of Illnesses and Injuries in Different Types of Child Care *Albert Chang*

The goal of the San Diego Safe and Healthy Children in Child Day Care Project (SAHCHI) was to demonstrate an accurate and convenient surveillance system to actively monitor illness and injury in children and caregivers in different child care settings. Small family child care homes, large family child care homes, and child care centers located in the city of San Diego were invited to participate. A two-step data-gathering activity was instituted that consisted of a "daily log form" and a follow-up interview telephone call. A total of 5,354 children who attended 171 child care facilities provided 112,629 child weeks of information over a 20-month period (June 1992 to January 1994). The study found that incidence of illnesses decreases as the age of the children increases. Children in family child care homes have more illnesses than do children in child care centers: 8.1 illnesses versus 5.9 illnesses per child year. There were 12,198 absent days due to illness (5.6 days per child year). As found with illness episodes, the incidence of absence decreased with age. A total of 3,595 medical visits were reported (1.7 visits per child year). Children in family child care homes had a greater rate of medical visits (2.8) than did chil-

dren in centers (1.3). The incidence of first-aid attended injuries was highest in small family child care homes, followed by child care centers, and lowest in large family child care homes. The incidence rates for medically attended injuries for small family child care homes, large family child care homes, and child care centers were respectively 4.8 per 100,000 child hours, 2.9 per 100,000 child hours, and 2.7 per 100,000 child hours. The incidence rate for all children five years or younger in all types of child care facilities was 2.9 per 100,000 child hours.

Knowledge and Attitudes Regarding Potential Risk of Human Immunodeficiency Virus Infection in Child Day Care *Sandra J. Holmes, Ruth Waibel, Ardythe M. Morrow*

The number of children attending child care has risen sharply in the past two decades and is likely to continue to rise as more mothers with preschool children enter the workforce. The prevalence of HIV (Human Immunodeficiency Virus) infection in children is increasing as a result of increases in the number of HIV-positive women of childbearing age and increasing longevity among infected infants. It is recommended that children infected with HIV not be excluded from child care. Although there has not been a case of transmission of HIV in the child care setting, it is important to consider the potential risk for transmission since HIV can be transmitted through contact with infected blood, and bleeding injuries are common among young children in child care.

Misunderstandings among many child care providers and parents concerning transmission of HIV has been reported. This lack of understanding was reflected in reluctance on the part of child care providers to appropriately care for HIV-infected children, and unwillingness among parents to allow their healthy children to attend child care with HIV-infected children. Further studies are needed to accurately assess the frequency and management of bleeding episodes in child care facilities. There should be strict adherence to standards for managing bleeding episodes. Accurate information regarding potential risk of transmission of HIV in child care settings should be disseminated to child care providers and parents of children who attend child care to ensure that knowledge concerning transmission of HIV is correct. Accurate knowledge and appropriate attitudes are essential for providing safe and caring child care environments that will enhance the well-being and development of all children enrolled.

Injuries among Children in Home and Out-of-Home Care *Jonathan B. Katch, Vincent Dufort, Margaret Brennan, Paul W. Stewart, John Fieberg, Marsha McMurray, Frank Porter Graham*

A community-based random sample of 657 children under six years of age was followed prospectively for one year with monthly computer-assisted telephone interviews of their caretakers. Information was collected on severe (medically attended and/or resulting in activity limitations) and minor injuries by type, cause, body part, place of occurrence, age, and gender. Information was also collected on any changes in child care situations (type of care and mean hours per week) at each interview. Log linear statistical modeling designed to handle unbalanced data with correlated observations was used as the primary tool for this analysis.

At the beginning of the study, 65 percent of the children received some care outside the home, the majority (34%) in licensed child care centers (the care arrangements for several children changed during the course of the study). However, over the period of the study, home care (HC) exposure accounted for about 59 percent of all exposure hours, followed by center-based care (CBC) with close to 29 percent and other out-of-home care (OOHC) with about 12 percent. A total of 971 injuries were identified as having occurred either at the child's own home or at a

Health, Mental Health, and Resiliency

regular place of out-of-home child care. Severe injuries accounted for only six percent of all injuries. Minor injuries were proportionally distributed among the three settings with 54 percent occurring in the child's home, 41 percent in CBC (including day care centers, preschools, Head Start, and other organized programs), and the remaining four percent occurring in OOHC (family day care homes, babysitters, or other out-of-home care). Most of the injuries were caused by falls (51%), followed by being hit by a blunt or sharp object (32%). The head or neck was the most frequent site of injury (44%). None of the reported injuries resulted in hospitalizations. Variation in the kind of injury according to place was most notable for human bites, with 60 out of 71 bites occurring in CBC. Burn injuries were more frequent at home, with 26 of 33 burns occurring at home. Adjusted minor injury rate differences were statistically significant between CBC and HC (63 per 100,000 child hours for CBC, 45 per 100,000 child hours for HC.) Differences between minor injury rates in OOHC (14 per 100,000 child hours) and CBC or HC were also statistically significant. While the adjusted CBC injury rates remained higher than HC and OOHC rates for severe injuries (3.5, 3.3 and 0.1 per 100,000 child hours respectively), no statistically significant differences were seen in rates of severe injuries among the three child care settings.

This is the first randomized, community-based study to use primary data to describe patterns of injuries to preschool children in the U.S. by type of child care. While severe injury rates do not seem to differ between care settings, they only accounted for six percent of all injuries in this study. The minor injury rate, being 1.4 times higher in CBC than in HC, deserves attention.

Health and Nutrition Problems in Head Start Children and Their Relationship to Poverty

Rosemary Barber-Madden, Clara Giambardino, Catherine Cowell

Full paper summary not available.

The results of a needs assessment of 220 Head Start programs in Region II Department of Health and Human Services (New York, New Jersey, Puerto Rico, and U.S. Virgin Islands) was reported. A regional health institute provided 350 health coordinators the opportunity to share knowledge on current strategies for future child health promotion activities.

■ Children in Context: Effects of Family and Child Care Stressors on Preschoolers' Physical and Mental Health

Chair: Abbey Alkon

Discussant: Charlotte E. Burchard

Presenters: Abbey Alkon, Janice L. Genevro

Preschoolers attending child care centers experience stressful events at home and at the child care center, although few studies have studied the impact of context-specific stress on children's physical and mental health. A NICHD-funded study of preschoolers was conducted in four child care centers to study the relationship between stress and health. One hundred forty-one children enrolled in the one-year cohort study. Fifty-seven percent (n=80) of the children were boys, 74 percent were Caucasian, and the mean maternal educational level was 18 years. The study included multiple measures of stress (home and center), environmental characteristics (home and center), children's behavior (rated by parents and teachers), and center-specific injury incidence.

The study team and child care staff developed a reliable, valid, and easily administered measure of contextual stress occurring in child care centers. Stress was defined as daily events, experiences, or demands that challenge the children's capacity to adapt and cope. The 21-item Childcare Events Questionnaire (CEQ) was completed by the teachers bimonthly. Results showed that the most frequent stressors were having a different (new or substitute) teacher, changes in daily schedule routine, and short staffing.

The effects of context-specific stressful events on children's behavioral and emotional adjustment as mediated by maternal anxiety were studied. The results showed that maternal anxiety mediates the relationship between major stressful events in the family and children's behavior problems. There was a significant interaction between maternal anxiety and daily hassles at home in relation to behavior problems as rated by mothers. Children who experienced frequent stressors at the child care center (CEQ) had more behavior problems as rated by their teachers compared to children with lower CEQ scores. Therefore, maternal anxiety is an important factor to consider when children are having difficulties adjusting to child care center environments. In addition, children identified with behavior problems by parents or teachers differ depending on the context in which they are observed, home versus center.

The children's environment, home and child care, also affects the preschool children's physical health, as measured by minor and more severe injuries that occur in child care centers. Preschool children with both externalizing behavior problems and major stressors at home sustain the most injuries in child care centers. Children who experience frequent stressful events in the child care center also have high injury rates and behavior problems, as rated by teachers. Therefore, preschool children's physical and mental health are affected by contextual factors in the family and child care environments.

Researchers conducting studies in child care centers should foster collaborative relationships with child care staff. During this study, the research staff met regularly with the staff, directors, and parents. The research team provided weekly visits by a health provider as a part of the study. This interdisciplinary approach was successful because it provided a mutually productive and supportive work environment.

Further studies may need to focus on the context-specific stressful experiences and subsequent child behaviors in order to improve the physical and mental health of preschoolers.

Health, Mental Health, and Resiliency

Injuries in Child Care: Child, Family, and Center Predictors

Abbey Alkon, Janice Genevro, Pamela Kaiser, Jeanne Tschann, Margaret Chesney, W. Thomas Boyce

A one-year cohort study of 141 children was conducted to study the relationship between children's behavioral characteristics and environmental stress in predicting injuries for three- to five-year-old children attending full-day child care centers. Four child care centers participated in the study. Fifty-seven percent ($n=80$) of the children were boys, 74 percent were Caucasian, and the mean maternal educational level was 18 years.

The research questions addressed were: 1) do stressful events in the environment (child care center/home) affect child injury rates; 2) does the quality of the child care center affect child injury rates; and 3) do children's behavioral characteristics and their home environments jointly predict injury rates?

Injury report forms were completed by teachers when an injury met the study definition of an injury, "an event that results in bodily harm, as reflected by a physical mark or a sustained complaint more than five minutes in duration." Children's behavioral characteristics were measured by teacher-completed CBCL questionnaires. Environmental stress was measured in the child care center by teacher-completed Childcare Events Questionnaires and quality measures developed by the research staff. The quality composite scores included the staff turnover rate, teacher educational level, part- to full-time staff ratio, and an overall quality scale. Home environments were measured by parent-completed questionnaires, Coddington's Major Life Events Questionnaire, and Boyce's Family Routines Inventory.

The results of poisson regression analyses predicting child injury rates per 2,000 exposure hours (equivalent to attending a center for one year full time) showed the following results: 1) younger children experienced more injuries than older children ($z = -4.0, p < .001$); 2) gender was not a significant predictor of injury rates ($z = 1.2, p = .24$); 3) children living in families with fewer daily routines had more injuries compared to children who had more family routines ($z = -2.4, p < .05$); 4) children with internalizing problems (e.g., socially withdrawn) had fewer injuries compared to children without internalizing problems ($z = -5.1, p < .001$); 5) children who experienced more frequent stressful events in the child care center had higher injury rates compared to children who experienced less frequent stressful events when controlling for age, gender, center quality, child behavioral problems, family stress, and family routines ($z = 7.1, p < .001$); 6) children attending lower quality centers sustained fewer injuries compared to children attending higher quality centers ($z = -4.0, p < .001$); and 7) there was significant interaction between teacher-rated children's externalizing problems (i.e., aggression, destructive behavior) and major stressful events in the family-predicting injury rates ($z = 4.4, p < .001$). Children with teacher-rated externalizing behavior problems who lived in families with many major stressful events had higher injury rates compared to children with externalizing problems living in families with fewer stressful events and children with low externalizing problems. These findings suggest that successful intervention programs should address both children's behavior problems as well as their environments (child care center and home) to reduce injury incidence in child care centers.

The Childcare Events Questionnaire: A Measure of Contextual Stressors in Child Care Centers

Pamela Kaiser, Abbey Alkon, Jeanne Tschann, Margaret Chesney, W. Thomas Boyce

Minor stressors (i.e., "hassles" in the context of school, peer relationships, play, and family) are important predictors of childhood behavioral and psychological problems. Preschoolers may be particularly vulnerable to stress due to their still-emerging developmental and coping capaci-

ties. Yet there is almost no empirical data on minor stress among preschoolers or on stress in child care settings.

The Childcare Events Questionnaire (CEQ), developed as part of a NICHD-funded longitudinal project examining the relationship between environmental stress and preschoolers' health, identifies the occurrence and distress of hassles experienced by preschoolers in child care centers.

In the scale development, stressors were defined as daily events, experiences, or demands that challenge the average child's capacity to adapt and cope. Item reduction of the initial generation of 232 objective, observable items cited with high frequency by an expert panel of child care staff was based on frequency, similarity, and three pilot tests. The final 21-item version tapped the occurrence of the previous day's stressors for each child and the presence of distress and reflected psychosocial, physical/developmental, and structure/format conceptual categories. Internal consistency was highly satisfactory (Cronbach's $\alpha = .83$), with satisfactory test-retest stability ($r = .44, p < .001$) when comparing data from two intervals of three months each.

The study sample included 141 three to five year olds (27% non-White) attending full time in four child care centers with high quality-of-care composite ratings. Lead teachers scored the CEQ for each child biweekly for one year. Teachers reported highly acceptable face validity, ease in recalling the stressors and children's reactions, and appreciation of the brief scoring time of one-half minute per child).

Results showed that the most frequently occurring stressors were teacher- and center-related, such as different (new or substitute) teacher, changes in daily schedule/routine, and short staffing. Total frequency of stressors was moderate; scores were transformed, standardized, and summed. Individual child and center variability for the average occurrence was found, with more stressors experienced by boys ($p < .01$), preschoolers in lower quality centers ($p < .01$) and by children who had more than two prior child care arrangements ($p = .01$). Age of entry into child care and hours of maternal employment were not significant. Although no linear relationship between age and total frequency was found, item analyses found that children under the age of four experienced significantly more change-related and physical/developmental stressors. A few interpersonal stressors typically evoked distress; however, distress data was not analyzed further because overall distress was very infrequent ($M = .58, S.D. = .74$).

In conclusion, the CEQ is an easily administered and reliable measure of teacher-identified contextual hassles that taps individual differences in stress occurrence and distress among preschoolers and centers. Future CEQ research will address questions regarding generalizability to centers of lower quality and to disadvantaged children, as well as adding stressors reflecting the more difficult-to-measure, yet important, ongoing interpersonal and environmental processes, such as waiting for individual attention and high noise and activity levels.

Predicting Behavior Problems in Preschool-Age Children from Maternal Anxiety and Stressful Events

Janice L. Genevro, Abbey Alkon, Jeanne M. Tschann, Pamela Kaiser, Margaret Chesney, W. Thomas Boyce

Data were reported from a study of 107 children (mean age = 47 months, $SD = 8$) enrolled in full-time center-based child care. Interrelations among maternal anxiety, the occurrence of major stressful events in the family, the occurrence of stressful daily events in the home and child care center, and mothers' and teachers' ratings of children's behavior problems were evaluated. Measures completed by mothers included inventories of major life events and daily stressful events, the Parenting Stress Index (PSI), and the Child Behavior Checklist/2-3 (CBCL/2-3). Teachers completed a biweekly inventory of child care center stressful events experienced by

Health, Mental Health, and Resiliency

each child and the CBCL/2-3. The Parent Domain of the PSI was utilized as an indicator of maternal anxiety.

Results of hierarchical multiple regression analyses with mothers' CBCL ratings as the dependent variable indicated that there was a significant interaction of maternal anxiety and daily life events in relation to behavior problems: mothers who reported higher levels of anxiety also tended to rate their children as having higher levels of symptoms of behavioral problems regardless of the number of stressful daily events reported. For mothers who reported lower levels of anxiety, the number of daily stressful events reported related positively to ratings of behavior problems. The occurrence of stressful child care center events did not account for significant variance in maternal CBCL ratings.

In analyses utilizing teachers' CBCL ratings as the dependent variable, neither the occurrence of major life events nor the occurrence of daily events related significantly to CBCL Total Problem Scores. Maternal anxiety and the occurrence of stressful events in the center related significantly and independently to teacher-rated CBCL scores.

Maternal anxiety was thus the only variable that consistently and significantly predicted both mothers' and teachers' CBCL ratings. The results provide a complex picture, however, of relations among stressful events and children's adaptation as rated in different settings. Analyses using mothers' CBCL ratings indicated that maternal anxiety and the occurrence of daily events interacted in relation to mothers' perceptions of their children's emotional and behavioral problems: mothers with higher levels of anxiety tended to rate their children as having higher levels of symptoms, regardless of the frequency with which stressful daily events occurred: NS the ratings of mothers with lower anxiety levels were more sensitive to the occurrence of daily events. In analyses using teachers' CBCL ratings, familial stressful events did not relate significantly to teachers' perceptions of children's problems, although the stressful child care center events did predict Total Problem Scores.

In addition to reflecting relations between maternal anxiety and child adjustment, ratings of observers in two contexts—home and child care centers—were sensitive to everyday events hypothesized to be particularly distressing to preschool-age children. These results suggest that the roles played by caregivers—including not only parents but other care providers—in recognizing as well as filtering or ameliorating the effects of stressful events on children's adjustment, and in promoting the development of children's capacities for the regulation of emotions and behaviors, merit further in-depth analysis.

Comments from Discussant: Charlotte E. Burchard

Pacific Primary School is a private, not-for-profit preschool, kindergarten, and child care program in a transitional neighborhood of San Francisco. The parents and staff are diverse in age, culture, race, ethnicity, economics, and family structure. While the parents are generally well educated, many are struggling economically because they are graduate students, medical interns, or employees of nonprofit organizations.

The center has a sincere commitment to conflict resolution, including a peace curriculum. Children learn to solve problems with words, rather than fists. Individual and group activities are provided to promote nonviolent solutions. Activities are available to empower the children. The curriculum is developmentally appropriate with open-ended activities, a balanced scheduled, routines and traditions, and positive interactions among children and adults.

Health, Mental Health, and Resiliency

Pacific Primary also has a strong arts orientation. There are two artists on staff. One is a puppeteer and sculptor. The other is a music and movement specialist. Additionally, classroom teachers provide opportunities for storytelling, creative dramatics, and visual arts.

Pacific Primary invests in its staff. Salaries and benefits are competitive with other high-quality early childhood programs. Staff development is funded. Many teachers and assistant teachers enroll in classes at local colleges or attend seminars for their professional development. All of the teachers and most of the assistant teachers work full time, providing consistency for children and parents. Because of the positive working conditions and the value placed on staff, there is a low rate of turnover.

After years of working together at the University of California, San Francisco and Pacific Primary School, we completed the circle by presenting at the Head Start Research Conference. The meetings in Washington, D.C. provided the opportunity for researchers and practitioners to share their findings and experiences. Our study was interesting, not only in its conclusions, but also in its process.

The UCSF researchers for this project were advocates for children, parents, and teachers. With the sensitivity and the manner of collecting data, the researchers participated in the team of advocates at the child care center. The researchers were not outsiders solely collecting data. They also contributed to the well-being of the people with whom they worked at the center. For example, the researchers acted as resource people for staff. The researchers recommended books and journal articles. They provided staff training and health care information. The researchers were productive, positive, and supportive. Because of their style of working, they were appreciated and valued by the child care center staff. This was an unusual and desirable relationship between researchers and practitioners.

In order to provide high-quality care for young children, it is important that the center philosophy is developmentally appropriate and the staff is nurtured. Families and staff will appreciate and value research if it is done in a noninvasive and supportive manner.

Health, Mental Health, and Resiliency

■ Research Perspectives on Community Partnerships for Effective Inclusion, Part I

Chair: Sharon E. Rosenkoetter

Discussants: Lisa M. Goldman, Peggy Stephens Hayden

Presenters: Ann Higgins Hains, Sara Holzman Lubar, Christine Burton Maxwell, Mark S. Innocenti, Sharon E. Rosenkoetter, Lawrence I. Rosenkoetter

Head Start was a pioneer in serving children with special needs in community settings. Back in 1972, Head Start legislation decreed that every Head Start program must fill at least 10 percent of its enrollment with children with disabilities. Three years later, the Education of the Handicapped Act was passed. Recently retitled the Individuals with Disabilities Education Act, this law has for more than 20 years required the provision of "free and appropriate public education" within the "least restrictive environment" for children who qualify for early childhood special education.

Requirements of both Head Start and special education for appropriate services with minimum pull-out for children with disabilities have been supported in recent years by a number of major movements. These include 1) research from multiple sources showing salutary benefits of community-based inclusion for children with and without identified disabilities; 2) new regulations that bring Head Start Performance Standards and the Individuals with Disabilities Education Act into congruence, making it easier for various community agencies to collaborate in serving young children with special needs; 3) effective advocacy for inclusion from parent groups and professional organizations; and 4) policy initiatives and grant funding at federal and state levels that support interagency collaboration and community-based services for all children.

The trend is definitely toward including children with special needs in community-based prekindergarten programs designed primarily for children without disabilities. However, research that sheds light on the processes through which effective interagency efforts are sustained remains at the "embryonic" stage, and challenges to inclusion remain. Well intentioned efforts to work together across agencies can be derailed by contradictory regulations, varied administrative structures, and separate funding streams among early childhood programs. Practitioners who share a commitment to children can be divided by differences in their training, philosophies about pedagogy or family involvement, program emphases, or teaching styles. Family members may support or resist inclusion or any of the myriad practices that may accompany it in a given community. All too often, the press of daily responsibilities, as well as the fear and uncertainty about new directions, may lead community planners to maintain a status quo of separate services for children and families who may have very similar needs.

Yet new partnerships are occurring. By studying them, we can learn much about future directions for inclusion in early care and education. This symposium reported the results of four multisite, multimethod research studies into collaborative strategies for creating quality services for all young children, via partnership between Head Start, early childhood special education, child care, Title I, and other community programs. While the papers differed in inclusion approach, geographic location, and research methods, the four studies share practitioner input and immediate applicability of findings to other settings. Discussants for the symposium included a parent of a child with disabilities served in Head Start and a regional technical assistance provider from Head Start early childhood special education.

Collaborative Planning in Communities for Young Children with Special Needs and Their Families *Ann Higgins Hains, Sara Holzman Lubar*

Six communities participated in a qualitative study that examined the factors that facilitated and inhibited the creation of a seamless system of services for children birth to five years with disabilities and their families. The communities represented urban, rural, and suburban sites. Each community identified an interagency planning team, which included parents and professionals from early intervention (birth to age three) programs, Head Start programs, public school early childhood special education programs (ages three to five years), and community child care providers. The goals were to examine existing services to determine gaps, to identify opportunities for collaboration in the coordination and delivery of services, and to develop a common process and document for serving young children with disabilities and their families. Specifically, the communities were asked to modify the early intervention programs' Individualized Family Service Plans (IFSPs), Head Start programs' Disability Service Plans (DSPs), and public school early childhood special education programs' Individual Education Programs (IEPs) into a combined process and document. During the two-year study, the six sites had open access to and encouragement from leaders in state agencies who provided technical assistance and support. The community sites were funded to meet together at the beginning and midpoint of the study.

In order to document the key factors in the change process, each community site participated in interviews at the beginning, middle, and end of the study. Each of the three interviews included the same site representatives: a parent, an early intervention professional, and a school district early childhood special education professional. The interviewer followed a semistructured interview guide that included questions regarding the ongoing and completed activities in the community related to creating a seamless system of services, any changes that resulted from their effort, and factors that facilitated or hindered the change process.

The results of the interviews revealed that many of the mentioned items were either seen as helpful in their presence or barriers in their absence. For example, the approval and support of local administrators were seen by some communities as helping the change process, but in other communities, the lack of administrative support was seen as a barrier. Likewise, if a small group of familiar people worked together and the group had common beliefs and understandings, it helped the change process; if not, it hindered the process. Finally, involvement of committed and motivated personnel and a cooperative group were important factors on both sides of the equation. Other items emerged as factors that solely facilitated or hindered change. Factors that emerged as solely facilitating the change process included sharing of ideas among sites, the availability of technical assistance, the focus on outcomes, and staff coordination and timelines. Items emerging solely as barriers included 1) the technically different agency and school systems and issues; 2) school district discomfort with the implications of multiple agencies and funding sources' providing services; 3) adequate time for personnel to work on the project; and 4) dealing with multiple other changes in agencies as the IFSP/DSP/IEP change occurred.

The results showed that three communities created common processes and documents for working with young children with disabilities from birth to age five and their families; one community completed a signed interagency transition agreement between the early intervention, Head Start, and early childhood special education agencies; one community developed comprehensive service coordination for children with disabilities from birth to age five; and one community created a comprehensive local interagency coordinating council for addressing early childhood populations (birth to age five).

Health, Mental Health, and Resiliency

Can Evaluation Research Promote Partnerships among Early Intervention Practitioners and Policymakers: Analysis from a Head Start/Public School Collaboration

Christine Burton Maxwell, Gail Porath

This presentation described results from a formative evaluation of a Head Start/Public School collaboration in a large urban area that was designed to provide full inclusion options for young children with special needs. Evaluation results are used to 1) describe differences among beliefs and perceptions of direct-service staff and administrative policymakers in implementing an interagency, collaborative early intervention model; and 2) outline the supportive role that evaluation can assume in promoting interagency collaborations.

The Head Start programs participating in the collaboration serve approximately 2,300 children in 25 community-based sites. Through the collaboration, public school early childhood special education teachers deliver direct child intervention, family support, and teacher technical assistance. The formative evaluation was conducted at the end of the collaboration's first and second years. Methods included focus groups, written surveys, document reviews, and structured interviews of participating staff and administrative policymakers. Content analyses identified themes that characterized the direct-service staff and administrative policymakers' beliefs about the interagency collaboration as an approach to implementing full inclusion for young children with special needs. These analyses highlighted differences between direct-service staff and administrative policymakers:

- 1) Direct-service personnel viewed the interagency collaboration as a vehicle for significant reform in early childhood education and intervention, with an emphasis on such preventative services as family support and teacher empowerment. Administrative policymakers viewed the collaboration as a vehicle for expanding capacity to serve children with identified special needs.
- 2) With these differing definitions of the collaboration's mission, direct-service personnel and administrative policymakers reflected other contrasting patterns of belief. Direct-service personnel were comfortable in immersing themselves in the collaboration activities as constructive, creative ways of working together with many possible unforeseen outcomes. Administrators were uncomfortable with the collaboration's ambiguities, and valued direct services as concretely measured by caseloads.
- 3) With their reform orientation, direct-service personnel sought to take ownership for constructing solutions to perceived flaws in a wide range of early education policies within both the Head Start and public school arenas. Given their view of the collaboration as a "program-to-be-implemented," administrators questioned the collaborating staff members' "probing" into these broader issues;
- 4) Administrative policymakers emphasized child outcomes as the valid outcome of early education and intervention. Direct-service staff viewed child, family, and staff outcomes as worth pursuing, but expressed much uncertainty and ambiguity in specifying the possible developmental advantages for the children with special needs who participated in the collaborative full-inclusion program.

These results are discussed in terms of their implications for evaluation research on interagency collaborations in early education and intervention. Three issues are highlighted: 1) the need for evaluations of collaborations to be broadly conceptualized and to include support in negotiat-

ing definitions of goals and effectiveness; 2) the need for evaluators to become partners in the collaboration and to adopt a long-term developmental perspective on the collaboration; 3) the need for evaluators to have knowledge of both child development and intervention and collaborative organizational development.

Disability-Focused Training in Head Start: Effectiveness and Implementation Issues

Mark S. Innocenti, Yong U. Kim, Nan Gutshall

This study used a two-group, quasi-experimental design to examine the impact of an activity-based intervention (ABI) inservice curriculum on Head Start employed paraprofessionals and on the children with disabilities in their classrooms. ABI is seen as a point of convergence between Developmentally Appropriate Practice and Early Childhood Special Education. This study examined the impact of the ABI curriculum on the teaching behavior of the paraprofessionals, changes in the classroom environment, and child outcome measures. This study was part of the Training Paraprofessionals to Provide Activity-Based Intervention (TABI) project.

Sixteen Head Start classroom in an urban western city that included 17 paraprofessionals (eight TABI) and 83 children with disabilities (36 TABI) were involved. Training activities that were occurring for all Head Start staff (regular group) were enhanced for the study through the addition of an activity-based intervention curriculum for the aides (TABI group). The TABI training consisted of a mix of inservice training sessions and visits by a training coordinator to the classrooms of involved paraprofessionals. Inservice sessions were structured around a videodisc curriculum. Mentoring visits focused on the application of the activity-based intervention with identified children.

The primary measure for this study was an observational instrument that assessed the program ecology: the behavior of teachers and the behavior of children. Also, all children were administered the Woodcock-Johnson Cognitive and Achievement and the Cooper-Farran Behavior Rating Scale.

The following results relate to specific TABI project hypotheses. Neither classroom activities nor teacher time as the activity leader were changed, but paraprofessionals were more frequently the activity leaders in the TABI group ($p=.002$). The teaching behavior of verbal prompting by paraprofessionals in the TABI group was statistically significantly different ($p=.01$), but the teaching behaviors of approval statements and verbal instructions were not. Children with disabilities in the TABI group were more frequently an activity initiator ($p=.004$). No statistically significant differences were found in child engagement between groups. No statistically significant differences were found on the Woodcock-Johnson Test or the Behavior Rating Scales.

Overall, these data are supportive of the TABI training activities. However, the impact was not as strong as expected in some areas and did not occur in others (e.g., engagement). No differences were found on standardized measures. As a result of the training activities conducted as part of this research, a number of training issues were identified. These issues fall into the general categories of communication issues, practical issues, research issues, and systems issues. Another issue not directly addressed by this study relates to the difficulty of correctly using the chain of behaviors that constitute ABI. Informal observation of the paraprofessionals indicated concerns with the correct implementation of the ABI technique. A final issue, and one that remains a major concern, is whether a Head Start program can support an inservice training as intensive as this one.

Health, Mental Health, and Resiliency

Lessons from the Pioneers: Merging Head Start, Early Childhood Special Education, and Other Services at the Classroom Level *Sharon E. Rosenkoetter, Lawrence I. Rosenkoetter*

A number of pioneers have attempted to cut through bureaucratic and human barriers and blend children, personnel, and services from two or more programs at the classroom level. At its simplest, this concept may merge Head Start and ECSE staff and children in a single classroom. In more complex evolutions, a community may choose also to include staff and children from child care, early intervention (birth to age three), Title I, state prekindergarten programs, family support, and other programs in blended early childhood services that may use a variety of classrooms, homes, and other community locations. The goal of such blending is to provide high-quality, individually appropriate services to all young children in the community, without publicly identifying—labeling, some would say, stigmatizing—individual children or their families.

This study was undertaken to learn from the experiences of pioneer communities, specifically, 1) what helped and what hindered them in building blended services; 2) what advantages and disadvantages accrued from blending; and 3) how they overcame common barriers. This project studied seven communities in five widely dispersed states that have attempted to blend Head Start and ECSE children and staffs in the same classrooms. Five types of data were collected in each of the seven communities: program documents, interviews with site directors, focus groups with center staff, focus groups with parents of children with and without identified special needs, and half-day classroom observations. All conversations were audiotaped for later transcription and analysis.

Respondents identified the following major reasons for merging Head Start, ECSE, and other services at the classroom level: 1) provides a focus on children as children, rather than on their individual or family characteristics; 2) eliminates stigma from early labeling of children or families; 3) attempts to meet a diversity of needs for every family in the community; 4) provides higher functioning models for every child; 5) shares staff expertise; 6) uses widely available resources; and 7) focuses community attention on prevention, rather than intervention, during the early years.

Parents (speaking without program personnel present) were typically highly complimentary of their children's and their own experience with blended services. Staff, too, were highly favorable about the values of blending. Strategies that may assist other communities initiating blended early childhood services include the following: use a generic name for the blended program and noncategorical names for participating children; reconfigure facilities so that a new identity is created, rather than one program absorbing another; emphasize leadership; give staff choices to give them ownership over the blend; emphasize the importance of personalities; create shared training to help the blend; give staff daily and weekly time to confer, reflect and plan; remember that families are at the heart of the blend; define roles to prevent confusion; resolve thorny issues early (e.g., meals and transportation); manage stress during the transition; consider challenging class compositions and adjust ratios; work in partnership with regional offices, RAP personnel, and state technical assistance providers; remember that blending takes time—years—to implement fully.

Comments from Discussant: Lisa M. Goldman

Research on Community Partnerships for Effective Inclusion: Implications for Programs

The implications from this research will be discussed within the framework of the proposed new Head Start regulations.

Health, Mental Health, and Resiliency

Early Childhood Development and Health Services

Head Start provides high-quality, comprehensive services that foster each child's social competence by supporting and nurturing the child's social, emotional, cognitive, and physical development.

Child: What outcomes do we want to look at with respect to Head Start goals? Measures: increase in IQ points, social interactions, attaining social goals on the IEP.

Teacher: What is the attitude and comfort level of the teacher and other direct-service staff toward working with children with disabilities? Use of peers as trainers; ensure their participation on the decision-making team.

Curriculum: DAP versus ECSE: there is a large gap between the philosophies of the two. DAP is child directed with children learning through their play. ECSE is teacher directed and skills focused. There is accountability of IEP goals and documentation of change. Further research on strategies to bridge DAP and ECSE is needed.

Family and Community Partnerships: Head Start must ensure that each enrolled family is supported in fostering their child's development and in attaining their personal family goals. Early Head Start and Head Start must make specific efforts to develop interagency agreements with LEA's and other agencies within their service area. We have learned to share information and resources; to obtain knowledge of programs' philosophy, services, eligibility, etc.; the importance of developing *trust* among agencies and individuals; to make sure to include the right people when developing collaborative groups; the importance of being creative problem-solvers (people can work together successfully if they can solve problems in a creative nonthreatening atmosphere); that there can be conflicting community priorities and initiatives that compete for time and resources within the community; the importance of available training and technical assistance for success; to keep the location neutral, sit at a round table and serve food.

Questions: Are there differences between urban and rural programs in their success at interagency collaboration? When classrooms and/or programs merge, is there a loss of identity? Do programs feel they no longer have what makes them unique?

Program Design and Management: This includes program self-assessment and monitoring and ensures that dynamic, highly qualified staff are selected for employment.

Staff: Remember that staff may need skills in research participation, such as learning new intervention techniques, teaming, completing new forms, developing a research model, and writing for publication.

Strategies: 1) allow for planning time for direct service staff; 2) provide joint training and staff development; 3) use peers as trainers; 4) provide opportunities to celebrate successes; 5) coordinate time and resources and support intercomponent collaboration; 6) when preparing the budget, allow for increase in staff, need for facilities modifications, and new equipment and materials.

Evaluation: 1) greater interest in qualitative measures; 2) greater interest in interactions and subtleties—not in numbers; 3) ask what the goals of the program are; 4) develop evaluation plan at the beginning of the year.

Comments from Discussant: Peggy Stephens Hayden

Implications for Policy

1. Policymakers should resist policies that communicate collaboration and inclusion as simply a "mandate" for compliance/program to be implemented. Rather, policymakers

Health, Mental Health, and Resiliency

should develop, implement, and monitor policies in a way that emphasizes allowing user (e.g., local programs) to be innovative and flexible in developing options that are responsive to the children, families, and communities in which they operate.

2. Policies should minimize regulatory funding terminology and related structural and procedural barriers to collaboration and inclusive services.

3. In order to promote innovations (e.g., inclusion, collaboration, training), policies should reinforce and make feasible local administrative support (leadership, communication, scheduling, etc.)

4. Policies should put in place or reinforce support structures (e.g., collaborative networks, joint training, information dissemination) that promote staff in various agencies developing a common knowledge base as well as shared values, understandings, and goals.

5. Policymakers should actively seek and use stakeholder input (families and agency administrators and direct-service personnel) in designing policies, policy implementation timetables, and strategies to facilitate policy adoption. This will encourage policies to be responsive to user needs and feasible for user implementation related to both the time and resources needed. Strategies should be used that allow user input and, thereby, promote ownership and adaptation responsive to user circumstances. Such ownership and implementation will occur at varied levels and over varying periods of time.

6. In promulgating policies, policymakers should consider the impact of policies in facilitating or inhibiting interagency collaboration, inclusion, or other desired change at the user level. Policymakers should realize that policies will not be implemented "in isolation," but within the current context of the state, community, agency, or classroom impacted by the policy.

7. Policymakers should develop policies and related structures that demonstrate the recognition that change is a slow process. It requires not only "rules, tasks, and timelines," but also relationship-building among administrators, direct-service personnel, and families within and across agencies at all levels (federal, state, local).

8. Policymakers should design and use evaluation methods to track and evaluate both the outcomes (what happened?) and the impact (did it make a difference?) of policy implementation as it relates to children, staff, families, agency administrators, and direct-service personnel.

■ **Inclusion of Children with Special Needs in Head Start:
An Ecological Systems Analysis, Part II**

Chair: Samuel L. Odom

Discussant: Jane DeWeerd

Presenters: Joan Lieber, Shouming Li, Jannette Wundrow, Sue Thomas,
Jules M. Marquart, Melissa Burka, Marci Hanson, Amy Liew, Susan Janko

Classroom Perspectives on Inclusion

Joan Lieber, Pamela Wolfberg, Shouming Li, Jannette Wundrow, Sue Thomas

Collaboration between Head Start and Public School Programs to Support Inclusion

Jules M. Marquart, Eva Horn

Family Participation and Community Integration for Children with Special Needs

Marci Hanson, Paula Beckman, Ann Kaiser, Amy Liew

**Multilevel Analysis of the Inclusion of Children with Special Needs in Head Start Programs:
Implications for Policy and Organization Development**

Susan Janko, Ilene Schwartz, John Bancroft

Paper summaries not available

Health, Mental Health, and Resiliency

■ Psychosocial Adversity: Risk, Resilience, and Recovery

"Conversation Hour" with Michael Rutter, Emmy Werner, Evelyn Moore

Chair: John Hagen

John Hagen: This is scheduled as a "Conversation Hour," and, thus, we have not prepared formal remarks. We have been doing a lot of talking for the last day or two and want to have a chance to get reaction and feedback. I mentioned the issue of critical periods within development and how particular kinds of interventions should be introduced—at what time and so forth. I see that both Michael's and Emmy's theoretical stances and their work suggest, in fact, that we should not assume that just because children are older or even into young adulthood that there still are not important interventions.

The other aspect has to do with implications for psychotherapy. Recently, a big issue is repressed memory and how people respond. We know that many therapists now have specialized in helping people, at least supposedly, reveal repressed memory, and oftentimes it has resulted in litigation. In some cases, it even entailed suing the estates of dead parents who were supposedly responsible for some of the negative experiences.

Michael Rutter: The critical periods notion is a complex one in which there is good evidence that certain kinds of experiences do make more of an impact at particular age periods than others. We know this for sure in relation to certain limited kinds of input. For example, it is clear that early visual input is important in relation to the development of the visual cortex and handling of binocular vision. It seems reasonable to suppose that there may be other parallels. However, there are several qualifiers that I would want to add.

First, we know relatively little about how far there are parallel critical periods for social relationships. The evidence is consistent with the notion that the first few years do have a particular importance in the establishment of social relationships, and that children who are seriously deprived of that have sequelae. However, the evidence on critical periods is that the notion of these being fixed or unalterable does not stand up. Even with phenomena where we know that there are critical periods, they are more flexible; they are more open to influence than we used to think.

The further point is that even where there are critical periods, they are only relative, and the sequelae are modifiable by what happens later. Therefore, the notion that if you have not done something by whatever age, you can forget about it later, is clearly wrong. Again, one has to question that this is something that applies particularly to the early years. The early years are of special importance for all phenomena because they have the particular feature of coming first. The things that happen then can influence what happens later because they set in motion chain effects. There are certainly periods later on that are particularly sensitive to other sorts of stimuli.

From an intervention point of view, one has to add a further feature, and that is to be concerned not just when the child is most sensitive, but when the opportunity to intervene is at its most effective. The two do not necessarily coincide. There are times when people are more receptive than they would be at other times. For example, there are certain times when people are more likely to listen to interventions designed to help parenting. From that point of view, the pre-adolescent years are probably advantageous because it is not "sissy" to be concerned with care of younger children, whereas in many western societies, at least for the males, in adolescence it begins to become so. Similarly, when the mother is pregnant, the opportunities for both the moth-

er and the father to listen about parenting issues has a salience. It is not critical in the biological sense; it is critical in the sense of receptivity.

The second issue raised is false memories and recovered memories. Let me try to summarize the evidence as I read it. To begin with, it is certainly clear that memories fade and re-emerge for a whole variety of reasons. There is nothing implausible, as such, in the notion that people may forget about something and then remember it later. What is much more controversial is the notion that this is particularly likely to take place with severely traumatic events, and I think the evidence is very unconvincing on that. In addition, there is the issue that one can completely forget something and then recover it later. It is possible, but what is much more common is for people to put it out of their consciousness but be aware of it, and then for it to be revived by later happenings. The idea of recovered memories has a plausibility as something that could happen. In the extreme form, I am more skeptical about it as other than an occasional event. However, having said that, the evidence that you can distort memories is overwhelming. Therefore, in terms of the techniques for reviving memories as part of therapeutic practice, or for that matter as part of judicial questioning, the chances of distortion are high. It is certainly well demonstrated that memories that people think of as absolutely real are in fact totally fallacious. We have to be very careful before accepting recovered memories in this way, because we know they can be false. In this difficult situation, you can neither say they do not exist or equally say that you can trust them when they are reported. The truth is a more complex mixture in which each case has to be looked at on its merits in a detailed way. The implications for the families concerned are clearly horrendous. They are horrendous if you deny memories that are, in fact, of events that did take place. They are horrendous if you accept as truth memories of events that did not take place. The responsibility on all of us when we are faced with situations like this is very high and needs to be handled with great circumspection.

Emmy Werner: Let me go from theorizing about critical time periods to something that we saw over time as we related different protective buffers in infancy, early childhood, and middle childhood to adult outcomes. Through analyses of longitudinal data, we saw that the support of a caring adult early in life predicted "significant quality" of adult adaptation, as did some basic competencies that included basic social and communication skills. In middle childhood, we clearly saw a significant statistical contribution to adult adaptation in the role of teachers. They could be along the whole range from kindergarten through third, fourth, fifth grade. Of course, teachers reoccur in children's lives at every stage. The impact of an early teacher should not be underestimated. We also notice that the availability of other supportive adults outside of the extended family, in the neighborhood, became more important in predicting future adult outcomes. And last, but not least, is the role of reading skills. Reading, of course, has implications for what will happen to a lot of children in adult life, not just in work, but also in all the other things that require communication facilities. Whether or not a child at least reaches this skill somewhere in middle childhood seems to be fairly predictive of adult adaptation in a very wide range of outcomes. It is not just work and school, but how well he or she gets along with peers, bosses, and so forth. These are just statistical relationships. In adolescence we find that self-esteem plays an important role in predicting future outcomes. However, self-esteem comes after competence.

I would say, just as Michael Rutter has said with regard to other longitudinal studies of his own, that we see in early adulthood a variety of periods where there can be major positive transitions. It is interesting that some of those seem to be similar regardless of geography and even generation. Michael mentioned the studies of the children of the Great Depression by Elder,

Health, Mental Health, and Resiliency

which took place in Berkeley quite a while ago. These children are now in their seventies. We find again, even though we now do not have the draft, and have instead a voluntary service, that service in the military, for instance, with the competencies, self-esteem, and opportunity for finding a constructive mentor and role model, can be an important transition in a positive direction in adult life, especially for the delinquent male.

We find in adult life the importance of contributions of service to the community. Those children who overcame "the odds" were already heavily involved in acts of required helpfulness when they were 8, 9, 10, 11, 12 years old, when they had to help out with their family. Those are the very adults now who, even though they are sandwiched between two generations—their aging parents and their teenage children—give much more time to the community. Apparently, it is a skill that has been learned and has been rewarded along the way. They find that a protective buffer in their life.

Finally, we find that the support of a healthy, well friend, spouse, or mate can turn a lot of people around. Of course, a lot of the people who took the opportunity to find that well friend or spouse were indeed people who had practiced some planning before, and who also tended to at least have some social skills that would get that spouse into their arms.

About memories—the memories that they speak about are child abuse. It does not seem to be a big problem in the population that I studied, which is predominantly rural, with many members of extended families available. Memories that help occasionally are traumatic events that they successfully overcame. For example, there had been two hurricanes. It is interesting how people refer back to the competencies they used to overcome the second one. Also, they worry about whether or not they had let their children down during the first one. Certainly, you cannot control a hurricane, but we find that financial problems, foreclosures, and incidence of post-traumatic stress reported in their children are much lower in the group that "sort of remained resilient" over time.

Evelyn Moore: I would like to make a comment on critical periods, because I am concerned that they are structured in a rigid way and are used to make decisions about what is going to happen to people. In terms of the implications of brain research, there is an impression that if we do not get to children before three months of age, they might become the biggest criminals, and that it is predictable. I have been a long-time believer in early education and care, but I am a little worried about where we are going with this resurgence of the critical period. Although it can help us with investment in children's early care and education, we have some responsibility in our profession not to promise too much either. That is the other side of the coin, with the complex issues we are dealing with in the lives of children and families these days.

I have always felt that this late bloomer's idea is one that we should not abandon. The military was mentioned, and how we have had conversions. There are people who have gone to jail, and suddenly they go to college and have a transformation. One of the things that is great about America is that there are these windows, and I would hope that we would not want to close any window that offers youth an opportunity to re-enter and to make good of their lives.

We are not clear on whether we have taught children before we test. Children may come to us from environments that are good; they have been stimulated and had ample opportunity for learning. They come into a program for infants in which the challenge of teaching is still on the table. I am not sure that we teach children before we say what they cannot do. In terms of these outcomes, I look upon them with some apprehension, particularly as we talk about certain groups of children in America's society that still face a lot of challenges.

Audience Questions and Comments

Comment: I wanted to make a point about critical periods. It seems to me that your general feeling is that the critical periods are not as important as we believed them to be in the past. That is possibly true, but we need to look at the critical period on a domain-by-domain basis. There are some areas of development that are more plastic and others that perhaps are less so. A case in point is language development. I would like to talk briefly about John Locke, a 1990s researcher. I do not know how many of you are familiar with his work, but he has done quite a bit on the critical periods in language acquisition. I am thinking in particular about his four stages. There is a second stage that is most critical, what I believe he calls the utilization acquisition period. In that period he says that the young child, probably one year to 18 months old, is gaining single words, vocabulary, and simple phrases. In the third stage, there is analysis and computation based on vocabulary and phrases that the child has learned in the previous stage. Therefore, for stage three and stage four, the production stage, to work productively, stage two is critical. Input at the stage two level is most important. His findings are that children who do not have sufficient vocabulary or phrase acquisition by the time they get to stage three have an impaired stage four, which is essentially impaired production.

I bring this up because I have experience working with very young Latino children, preschoolers, some of whom were going through the High Scope system in Alexandria last year. Many of these children come into the system language delayed, not only in English but, in fact, also in Spanish, which is their first language. The speech therapists there, many of whom are bilingual, have a difficult time trying to get the child to learn English, because the child does not necessarily know the words in Spanish. Therefore, their work is based on concept formation and all sorts of other things that go beyond speech acquisition. With certain developmental domains, critical periods are as critical as we originally thought they were.

The other point I wanted to make is that Michael Rutter talked about cognitive appraisal, processing, and planning as being protective mechanisms, protective factors, or at least involved in resiliency in a positive way. The Latino population in this country is a high-risk population for whom the issues of resiliency are germane. If many of the children are coming into the system language delayed and are not being helped in the way they need to be helped early on in life, it is conceivable that language development will occur, but will still be less than it would have been if they had gained the help they needed at the right time. That has some implications for resiliency, because cognitive appraisal, processing, and planning primarily rely upon language ability. Some of those characteristics may be somewhat compromised by not taking the critical period into consideration or giving it as much importance as we should.

Michael Rutter: One has to think about critical periods in terms of what is desirable in facilitating and what is necessary in an absolute sense. The sort of evidence that you put forward is persuasive. Where I think the evidence, however, goes in the opposite direction is if you are going beyond that to say that if you have not acquired language by a particular age, it is too late. For example, one of the studies we are currently engaged in is a follow-up of children from Romanian orphanages who have been adopted into U.K. homes. These are children who were unbelievably deprived. Over half of them were below the third percentile in weight, and over half of them were functioning at a severely retarded level at the time they came to the U.K. The conditions in which they had been reared are beyond imagination. However, although almost all of them were not speaking by the time they came, they have acquired language with few exceptions.

Health, Mental Health, and Resiliency

This group came into the country up to the age of three and one-half. Their degree of recovery is astonishing. We did not get measures of developmental level when they came, but we did use the Denver as a way of getting parents to give us the various skills that the children had and then looked at what they were like at follow-up. We do have contemporaneous data on some of these things, like whether they were speaking, walking, and even sitting up, because a number were not even doing that. By the time they were followed up at age four, the mean rise in developmental quotient was 60 points. It is a spectacular rise. I would not want to place too much weight on the specifics of that, because the measurement leaves something to be desired, but the gains are spectacular by any standard.

Similarly, to move to a totally different group, in the group of autistic individuals whom we followed into adult life, it is true, as Leon Eisenberg pointed out many years ago, that the outcome is influenced by whether the children have useful spoken language by age five. However, there are children who attain spoken language for the first time after that. The oldest that I have seen is at age 14. His language is far from normal, I have to say, but it is spoken language. Before that, the next oldest is 12. Before that, the next oldest is eight, and then it clusters a bit more.

Therefore, there are sensitive periods. I prefer "sensitive" to "critical" because it is not absolute. There is no doubt that if you have not gone through what is ordinarily expected early on, then later development is compromised to a degree. However, in spite of all of that, the recovery can be quite astonishing. We have to seize what can occur and ask the question, given that it can occur like that, why it is that we do not do better in terms of the children that we see.

Question: Based on your reading of the cognitive literature and cognitive development, if you were designing a curriculum for preschool children, what would you put in as the critical things that teachers should be spending their time doing?

Michael Rutter: I am neither an expert in cognitive development nor an expert in teaching young children. Therefore, you must accept my suggestions with those two important caveats. However, there are certain principles that I am reasonably confident about. They are simplistic but nevertheless important. The first is that the children are not passive recipients of the environment; they are processors of the environment. Therefore, we need to think of what we do with children, not what we do to children. The second is that children learn to a considerable extent through conversational interchange. One would want to place a high premium on that and on what the children are doing. It is not bombarding the children with talk; it is at least as much listening to what the children say and speaking back in a way that builds on that conversation. For example, there is the study that Jenny Hewetson and the late Jack Tizard did in London schools on a socially disadvantaged group, looking at children's progress in reading. They asked the parents not to read to the children but to listen to the children read, and the children did substantially better. That was so, despite the fact that these were mostly immigrant parents whose knowledge of English was not very good. A third feature would be an emphasis on the children having control over what is happening. I say that for a variety of reasons, partly because the evidence suggests that children, from an early age, need to have confidence that they can influence what happens to them. Obviously, the way a 3 year old can influence is different from a 13 or a 33 year old, but, nevertheless, the principle is an important one. Also, skilled teachers that I have observed often place a great deal of emphasis on the children being able to monitor their learning in ways in which they can only move forward. Let me give an example that illustrates the point. A skilled teacher, amongst other things, did a lot of teaching of primary school children with their

Health, Mental Health, and Resiliency

multiplication tables, which many children find difficult. He had schemes that he called jam turnovers and apple turnovers, which were criss-cross squares in which the children had to either multiply in a logical system or all jumbled up and time themselves. They scored themselves, and the scores they got were a combination of accuracy and time. The point is that it is virtually impossible to go backwards in a system like that. Even if you do not learn more, you will do it a little faster. Watching him teach the children, it was obvious that the children loved it and that they felt that they were doing better and better all the time. That was very important.

That ties in to my last point, that a sense of being able to succeed is important. Most remedial teachers would tell you that is half the battle. Many of the children have learning difficulties of a cognitive kind, but half the problem is that they do not feel they can succeed. Overcoming that is a lot of what it is all about. These are some of the general issues that derive out of developmental research. The ways in which it is accomplished are many and varied. Skilled teachers do not do it all the same way, but they have common elements in their approach.

Emmy Werner: I would like to add one thing in response to your statement, which is of concern to me since I am in California. You raised the issue about whether Latino children, because of problems with language, will not be able to self-reflect, which presumably would be one mechanism by which they could convert hurt and adversity into "resilience." You are absolutely right that there are sensitive periods of language development and especially so for bilingual children. What you are describing is a school system, and this is a social policy issue in my state, where people do not understand that it takes about eight years to really master any language. I happen to have grown up with two languages simultaneously, which were not English, and it then takes a while to learn a third and a fourth. Most of the children who have reading problems in our schools are children who have been thrown into our system not having mastered the stages of language acquisition in their original language. The point is, however, that if in early childhood intervention programs you have a large number of children who start with a language other than English, that is one of the most important things you need to do besides giving good nutrition and health.

Question: Fifteen or 20 years ago, Tony Earls did an epidemiological study and found that more mothers who were mentally ill use child care than mothers who were mentally healthy. Also, Mary Vacheneros had findings about attachment relationships and mothers who were depressed. As a researcher and also as someone who is asked to advise people about early intervention, what do we do with this knowledge in terms of mothers in our society who are depressed and take care of their young children? Do we try to promote a close interaction, or do we take a lesson from some of this data and try to advise them about getting their child in other care?

Michael Rutter: That is an important question, and I do not know that I have a generally satisfactory solution, but let me make a few comments. First, it is helpful to be frank with children in terms of their parents' troubles. This needs to be done in a way that is appropriate to the age and circumstances of the child. It is easy for children, especially with parental depression, to respond to this in terms of the hostility, irritation, and so forth that they experience, rather than recognizing a parent who is troubled. The study that John Clauson did some 40-odd years ago indicated that in some respects, families found it easier when the parent was psychotic and was obviously ill than when they were depressed. Then they knew that the parent had sort of gone bad

Health, Mental Health, and Resiliency

on them. Therefore, the first thing is to try to be frank with children; that is to say, I would try to help the parents to be frank with the children. It is much better that they do it.

Second, I accept the implication of what you say, that parents can be damaging in having an overly close relationship with their child. Using their child as a comfort object is not necessarily good for the child. I do not know that necessarily means that one needs to think of out-of-home care, although that would be one alternative. One can think in terms of fathers, older children, grandmothers, grandfathers, or other relatives sharing the care of the child. Talking with the family as to how this can be done is a helpful way of approaching it. One can also talk about what can be done in terms of the child's interest outside the home. It is important that children do not feel they have to rush back to look after mom or dad, as the case may be. That is not to say that it may not be useful and indeed giving of responsibility, provided that it is within limits. The ability to distance can be protective, which does not mean that the relationship with the sick parent is not still important. It is a question of how it is used at the time of crisis.

Question: What are the things we should be thinking about in terms of Head Start program emphasis, based on protective mechanisms? What are your ideas about what we should be trying to implement as mechanisms that will protect parents, their parenting role, children, and their development?

Evelyn Moore: I will start this conversation about parents. Our talk is better than actions in terms of parents and parents' roles and involvement. Parents tend not to be peers unless they are a middle-class or affluent parent. They are pretty much in control of their children's education even though they may be in a public school system. When we use the word "parent," we really mean powerless parent, or parents who feel powerless, even though they may be middle-class parents. Like the children, we need to build confidence in parents and learn how to have parents as peers, as partners in the education and development of their children. Head Start has probably done a better job and can be a better teacher than probably any other program with the exception of Chapter One, which has a strong parent role. This is an area that holds great, untapped promise. If you are a parent, you know what you have been able to do in your role as a parent in determining your child's future. If we can make that possible for more parents, there is hope for our children, because there are things parents know that we do not know.

I am intrigued with the idea of having conversations with your children and the importance of that in language development. In many homes in African-American communities, children are seen and not heard; children are told to be quiet a lot. To be quiet is to be a smart child. Yet we are saying that children need to be having conversations in order to promote language development that promotes cognitive development. However, some children are having conversations with their parents. It may be a different kind of conversation and a different way of communicating. If parents knew that they needed to make some adjustments in that, and we could help them understand that better, it would make our jobs a lot easier.

Question: This is a fairly pragmatic question, but as a researcher, when I hear the discussions coming again and again about the importance of confidence, feelings of empowerment, self-efficacy, and self-esteem, my question is: When can we measure and what are the best ways to measure it? Can we get some indicators of early success? It seems to be face valid and intuitively obvious to many people, but on the measurement side there are lots of challenges. What kinds of suggestions do you have?

Health, Mental Health, and Resiliency

Michael Rutter: I do not have very good answers on that. I would simply say that I am skeptical of questionnaire measures of features like this for several reasons. One is that most of the questions you can ask about self-esteem, self-efficacy, and so on, are comparative. Therefore, it is a question of who you are comparing yourself with. If people are differing in their comparison group, you may end up with some misleading answers. There is the practical reason, too, that you have to have different formats for using questions with young children. The measurement issues are quite tricky. Interview approaches would be my preference over questionnaires to a considerable extent, by getting children to talk about what they do and how they approach things. Observational measures of how children tackle different situations may also be helpful. I do not know that anyone has a satisfactory range of measures of this kind. Certainly I have not.

Question: I would like to address the issue of resilience. Is there some danger that if you emphasize resilience, there will be those who turn it around and say that if people are resilient and can recover, why should we do away with risk factors?

Michael Rutter: Yes, of course there are dangers. However, if you feel that it is risky going ahead on the basis of knowledge, try going ahead on the basis of ignorance and prejudice. Politicians take what they want. There is an amusing side issue in relation to research we did in schools in the 1970s. The book was published in 1979, which coincided with the election of Margaret Thatcher. Our findings were quoted by both political parties in their manifesto, but of course, they each took different aspects of our findings. I am aware that the sort of things that we have done have been misquoted and have been used to justify the unjustifiable. All one can do is to try to be as direct as one can, not only about the findings, but the implications of them, and to try to put the record straight when that is necessary. Not to get the evidence and not to be willing to speak to broader audiences about scientific findings is not a way forward. We have to do that, knowing the risks. We can be prepared for those risks as best we can, but whether we like it or not, findings will be misused. All we can do is to try to diminish it and correct it when it happens.

Emmy Werner: What bothers me is that we are using the term "resiliency" right now among many professionals in welfare, education, and child care so that we can justify our own existence. For a while, we were risk removers; now, we are resiliency fosterers. What strikes me is that there is a lot of enthusiasm about the concept because it is so quintessentially American. It is the Horatio Alger concept. It also brings out this hope that we will reach a stage where life will forever be without pain, suffering, depression, and so forth which, of course, is insane. I do not want to discourage you from fostering resiliency either in yourself or others, but we have to be ready when we ask for money from granting agencies, including the federal government or state government, to say something about where the beef is that we package in that program that we call fostering resiliency. It is showing in some systematic way positive changes in groups of children that you have chosen to help with risk management. Head Start can be looked upon as a program that fosters resiliency, but look how long it has taken us to say that we need to show the rest of the world that there are some positive changes.

Comment: One of the components of Head Start is parent involvement. I have been involved in teenage pregnancy. I am a mental health person involved with mothers who attempt suicide, wish to die, or wish to kill their child. I am also involved with grandparents who are primary caregivers. We see a good number of psychosomatic illnesses as they perform their primary par-

Health, Mental Health, and Resiliency

ent duties. Not only do we need to work with the child, but we also need to work with the parent who is encountering feelings of love, hostility, hate, guilt, or just the frustrations of being a parent. We need a program to help them to know what parenting is, as well as a structured program with the child.

Michael Rutter: The issue of involving parents is an important one. However, it is a two-edged sword in that sometimes bringing parents into preschool programs has a demoralizing effect on parents, who feel like failures in comparison with the skills of the teachers, as Urie Bronfenbrenner pointed out some time ago. Research over the last 20 years has confirmed both the advantages of bringing parents in if done in the right way and the dangers if done in the wrong way. We need effective interaction with parents that enhances parental self-esteem and skills and does not de-skill parents.

The other aspect that worries me about parental power is that at its best, it is quite rightly allowing parents to have the say that they should have in what happens with their children. At its worst, however, it takes responsibility away from the professionals who are dealing with the children. We do better to trust professionals to do a good job while at the same time having a fall-back position in which something could be done about the minority who are not doing a good job. I am in favor of parental involvement, but I do think that how it is done is critically important.

Evelyn Moore: I would like to make a couple of comments on this. First, one of the tragedies of our system is that we are not trained to work professionally with parents. It has not been a requirement that we learn to work effectively with parents, to build relationships that can promote the development of children. Second, there is a problem in America, particularly in our urban school systems, of trusting professionals with our children. In fact, they have not been able to step up to the plate and succeed in any significant ways. Here in D.C., the longer children go to school, the worse they do. One of the saving graces has been parents being able to navigate and help make the system responsive to their children. I also would mention that Head Start has offered an opportunity for professional growth to parents. Many parents have been hired into Head Start programs. Consequently, they have had an opportunity to become educated and to get on a professional track that enables them not only to contribute to other children, but to contribute to the development of their own children. One of the strengths of Head Start is that career track offered to parents.

Richard Gonzales: I am a Head Start director in New York City. The point that you made about not being trained to work effectively with parents is an important one, attached to the point about offering professional development for parents. What has happened over the past years is that as many of the parents come into the programs, we expect that because they have become a staff member, all of a sudden they are supposed to have skills that they did not have three weeks prior when they were a parent. One of the things that we are trying to do now is to build up the skills, particularly of the family service staff, many of whom are parents. We talk about the importance of parents advocating, and yet many times we expect them to make decisions without taking them through the steps of learning how to make those decisions. We put them in a situation to decide what is best for their children, but we have not necessarily given them the background on how to make those choices, or to know what the factors are that lead to good decision-making. We are on the right track, but the skills development in the areas of working with par-

Health, Mental Health, and Resiliency

ents, developing professionally, and understanding how to use the research knowledge that is being developed, are still fragmented, and we have not figured out the most effective ways to bring it all together.

Emmy Werner: Most of the studies on resiliency are based on populations where people did indeed pull themselves up by their own bootstraps with no intervention programs, not formal ones like Head Start. Most of the people on whom those data are based pulled themselves up with the help of some extended family and neighbors. What I am wondering about is how much you can generalize these findings to ordinary people. How much can you generalize them to people who now "qualify" for an intervention program for a variety of reasons, whether political, financial, or whatever? I deal mostly in California with Latino, Cambodian, and Asian-American parents. If you ask them what they want for their children, it is sometimes quite different from what the early interveners think they should want. At least one ought to ask the parents, as a matter of courtesy, what they are interested in. It is not that they might totally disagree, but their ideas might be different from ours.

One other thing that parents ask is how to access available services. Let us take as an example the federal law for the development of disabled children that extends services to children at risk as infants. We have an early and periodic screening program. Hardly anyone who qualifies for this in my county knows about that except educated parents. I had a Korean student in last quarter, and I gave it as an exercise. She is a teenage mother. I asked how she would go about accessing services that are in the book. Her answer was wonderful; she said she would call 911. I thought this was an exceedingly wise answer. When you look in any telephone book, you have to be an expert in unraveling where these agencies are, what they mean, and so forth. Any program that tries to involve and help parents should spend time teaching parents how to access the services available to them.

After 30 years, Head Start still serves only about one out of three children that are eligible. What is it about the parents who get into Head Start in comparison with the parents who do not get in? Possibly, some of the positive results of Head Start comes from the fact that it is the more assertive parent, the one who knows how to access information, that utilizes that opportunity. What about the two thirds who are not in? I understand that in some places they take the most "at-risk" child, so maybe that is the criteria. The whole issue of effectiveness of Head Start hinges to some extent on the kind of parents we select for the program. We have little parent data. I realize it is a problem for research in general, but it needs to be addressed when we talk about parent involvement.

Health, Mental Health, and Resiliency

■ The Resilient Children Making Healthy Choices Project: Translating Resiliency Research into Practice

Chair: Susan R. Geller

Discussant: Shepherd Zeldin

Presenters: Susan Geller, Bobby Beckham, Gwyn George, Kathleen Bodisch Lynch, Judith Semon Dubas, Joseph Galano

This symposium consisted of three related papers describing a comprehensive evaluated project offering professional development and a prevention curriculum for preschool teachers to equip them with skills and effective interventions to counter the negative effects of stressors such as violence and substance abuse on the development and education of young children. The Resilient Children Making Healthy Choices Project (RCMHC) is the product of a successful collaboration among program developers, practitioners, and university evaluators and researchers to build resiliency in at-risk preschool children.

The program developer from the Virginia Institute for Developmental Disabilities at Virginia Commonwealth University (VCU) summarized key studies in resiliency research that formed the basis for the development of the project. By forging partnerships with key community stakeholders from Head Start and other early childhood programs, the program developer, along with a consultant team of preventionists, applied resiliency research to early childhood practice. The basic premise of the project was that preschool teachers could serve a facilitative role in building skills in children that would act as protective mechanisms against risk.

The intervention consisted of teacher training and a resiliency-based preschool curriculum to provide a framework for trained teachers to introduce specific prevention strategies to young children. The interactive teacher training was designed to enhance teachers' knowledge and skills in guiding children in decision-making, nonviolent problem-solving, appropriate expression of feelings, prosocial behavior, and healthy coping. The lessons of the curriculum were written to relate to specific resiliency characteristics—social competence, problem-solving, and autonomy. The training and curriculum were piloted during 1994-1995 in 10 Head Start and other early childhood classrooms in Virginia.

The project evaluators have been vital partners with the project developers in all aspects of the program development process—planning, implementation, management, and improvement. The most important feature of the RCMHC project evaluation was its utilization focus. Participating teachers were actively engaged in the project evaluation and remained committed to it throughout the pilot program.

The process evaluation consisted of 1) lesson feedback sheets completed by the teachers after leading each lesson; 2) implementation-monitoring observations conducted by project staff; and 3) monthly group interviews with the teachers. During the symposium, the internal project evaluator conducted an interview with two teachers who participated in the pilot, providing them an opportunity to report on the project's effects on their teaching skills and their observations of behavioral changes in participating children.

Members of the evaluation team from the College of William and Mary reported findings from a quasi-experimental study that examined RCMHC child and teacher outcomes. Data revealed that teachers from the intervention group showed enhanced interactional skills designed to strengthen children's resiliency and improvements in their ability to respond effectively to hypothetical sensitive situations. Children in the program made gains in social-emotional development and improved in their ability to appropriately label emotions. Higher fidelity of implementation was associated with enhanced socioemotional development of the children. Areas for future research include the addition of a companion parent education component. The challenges

associated with applying resiliency research to effective practice and their implications for policy development were discussed.

The Program Developer's Perspective: Collaborating to Create an Early Childhood Substance-Abuse and Violence-Prevention Initiative *Susan Rose Geller*

Many young children growing up in America today are regularly exposed to substance abuse and violence, placing them at increased risk of developing attitudes and behaviors that support such antisocial, health-compromising lifestyles. Head Start programs are challenged to develop innovative services and creative partnerships to meet the needs of children and families as they face multiple stressors in their lives.

The Resilient Children Making Healthy Choices Project (RCMHC) is an early childhood substance-abuse and violence-prevention initiative that exemplifies an effective collaborative arrangement with Head Start. The project, developed at the Virginia Institute for Developmental Disabilities at Virginia Commonwealth University, is based on the rich body of international resiliency research, which indicates that while there are a host of risk factors that increases the likelihood of children developing future problem behaviors, there are also environmental conditions that help buffer children from negative influences and contribute to the possibility of their having more favorable, positive outcomes. Such protective factors foster children's resiliency—their ability to overcome adverse life conditions and develop into healthy, socially competent adolescents and adults.

In order to design a program that applied research to practice and was responsive to communities' needs, the program developer forged partnerships with key community stakeholders from Head Start and other early childhood programs, along with a team of prevention experts to develop the RCMHC Project. Practitioners expressed serious concerns that many children they worked with were affected by substance abuse and violence in their homes and neighborhoods, as demonstrated through their play and social interactions. Teachers expressed discomfort and a lack of knowledge and skill about how to respond to the children, and often felt hopeless about the children's future. Teachers were seeking specific strategies that could help them guide the children in developing positive attitudes and behaviors that would begin to lead them to healthy, drug-free lifestyles.

Consequently, the project was designed to strengthen protective factors within the preschool environment and enhance characteristics of resiliency within at-risk preschool children. The intervention consisted of two major components: teacher training and the development of a resiliency-based preschool curriculum. The 43-lesson curriculum provides the framework for trained teachers to introduce specific prevention strategies to young children that relate specifically to characteristics of resiliency: social competence, problem-solving, and autonomy. The curriculum is designed to build children's skills to make healthy choices, solve problems nonviolently, and cope in healthy ways. The training and curriculum were piloted during the 1994-95 school year in 10 Head Start and early childhood classrooms throughout Virginia.

From the beginning, evaluation has been an integral part of the project. As demonstrated in the other papers of this symposium, the evaluators have been vital partners with the project staff and practitioners in applying the evaluation results to all aspects of the program development process—planning, implementation, management, and improvement. This has helped to ensure that the project training and materials are appropriate, easily implemented, and effective.

Health, Mental Health, and Resiliency

The Teachers' Perspective: Providing Teachers with Tools to Build Resiliency Skills in Preschool Children *Kathleen Bodisch Lynch*

Because the RCMHC Project was in its developmental phase, process evaluation was deemed to be particularly important. Process evaluation searches for explanations for the successes, failures, and changes in a program; sets out to understand and document its day-to-day reality; and includes perceptions of people close to the program about how things are going, because in the real world people and circumstances shape programs in ways that are rarely trivial.

In the RCMHC Project, teachers were engaged in the evaluation process from the project's inception. They were reminded that this was a "pilot project" and told they were "co-pilots." Teachers were acknowledged to be the experts in what works and does not work in real classrooms with real children, and they were informed that their feedback would be used to make improvements in the project's training and curriculum. Teachers took their role as partners in the evaluation seriously, as was evident from the 100 percent return rate of Lesson Feedback Sheets, forms on which teachers gave their opinions about the ease of use, effectiveness, and appeal of each lesson. This 100 percent return rate represented 431 completed sheets sent back by 10 teachers on a predetermined schedule over a six-month period.

A second component of the process evaluation was Implementation Monitoring Observations. Project staff observed each participating teacher at least twice, and rated the teacher on the extent to which the approaches and messages of the curriculum were delivered with integrity to the project guidelines. Data were used to shape training sessions and to modify the RCMHC curriculum and materials.

The third component of the process evaluation was monthly Teacher Feedback Meetings. Through a group interview process led by the project's internal evaluator, these meetings helped project staff delineate and appreciate the teachers' successes and difficulties with project implementation. The following are examples of questions posed by the evaluator and the responses of the teacher.

Evaluator: How can you, in your role as Head Start teacher, help to build resiliency in your children?

Teacher: We have the children only seven hours out of the day, but we can equip them so they can make healthy choices in whatever situations they are in. It is very possible in the classroom setting to enhance protective factors and decrease risk factors.

Evaluator: What changes have you observed in yourself as a teacher that you attribute to your involvement with this project?

Teacher: The project develops resilient teachers as well as resilient children. It let me understand that I can provide children with tools to help them solve their own problems; I don't have to "fix everything." I have greater respect for the children's ability to handle what comes their way.

Evaluator: Why do you participate in the project evaluation?

Teacher: We were made to feel that our feedback was a significant component of the project. We knew that project staff wanted to find out what worked in our classrooms, and we saw changes made in response to teachers' comments. Our evaluation helped to improve the program.

The Researcher's Perspective: Assessing Project Effects on Teachers and Children

Judith Semon Dubas and Joseph Galano

The roles of teachers, schools, and the environments they create have received relatively little consideration in the study of resiliency processes. The present study describes the short-term effects of the Resilient Children Making Healthy Choices (RCMHC) project on preschool teachers' competence and preschool children's social competence, problem-solving skills, and autonomy. Evaluation included a thorough process component as well as multiple outcome evaluation strategies. A pre-post comparison group design was used to assess effects of the program on teachers and children. In addition, a smaller scale intensive evaluation employing individual assessments and behavioral observations to measure child outcomes was carried out in two classrooms. Three major research questions were addressed: 1) does participation in the program improve preschool teachers' general competence and specific knowledge about dealing with sensitive issues in the classroom; 2) does teacher participation in the program result in enhanced social competence and adjustment among the preschool children in their classrooms; and 3) is fidelity of implementation related to differential teacher outcome? That is, are stronger effects found for teachers who were more likely to follow the project curriculum than for teachers who did not implement the curriculum as intended?

Through a model program implemented in 10 Head Start and other community-based preschool classrooms, teachers were trained in the use and integration of resiliency-based substance abuse/violence prevention strategies in their teaching practices. The Intervention group consisted of 10 teachers, 11 instructional assistants, and 185 children; the Comparison group had 4 teachers, 2 instructional assistants, and 55 children. The groups were equivalent in terms of child demographic information and level of teacher training.

An outside observer rated each teacher using the NAEYC scale on Teaching Practices: Interaction among Staff and Children and a project-developed Implementation Monitoring Observation Form. In addition, teachers completed surveys that assessed their knowledge about risk and resiliency and how they would respond to situations involving substance abuse issues. Child outcomes included a project-developed Behavior Rating Scale that assessed socioemotional development of the children as assessed by their teachers. Observational measures were also obtained at one Intervention and one Comparison site that assessed social problem-solving, emotional identification and naming, helping, sharing, and response to peers' distress.

Analysis of outcome data using repeated measures analysis of variance revealed that teachers exposed to the intervention showed enhanced interactional skills designed to strengthen children's resiliency and improvements in their ability to respond effectively to hypothetical situations involving substance abuse-related incidents. Children participating in the program made gains to social-emotional development and improved in their ability to appropriately label emotions. Finally, higher fidelity of implementation was associated with enhanced socioemotional development of the children.

Several additional areas have been targeted for future research, including the addition of a companion parent-education component. This preliminary evaluation highlighted the beginning of a successful collaboration among practitioners, researchers, and policymakers and the ideology and values that guided the partnership. Finally, the challenges associated with operationalizing social competency, the need to include predictions concerning variation in fidelity of implementation as part of the prevention science strategy, and the implications these findings have for the roles of teachers and schools were described.

Methods for Assessing Low-Income Minority Families

■ The Measurement of Developmental Competencies: Implications for Head Start Research

Chair: Cynthia Garcia-Coll

Discussant: Gina Ruther

Presenters: Jacquelynne Eccles, John Modell, Deborah Stipek, Cynthia Garcia-Coll

Cynthia Garcia-Coll: One aspect of Head Start research is determining how well our programs are working. One way to approach that is to look at one of our main indices: the child's development. Are children doing better in whatever indices we use? The four of us are part of a network that Jackie directed from the MacArthur network. We have been struggling for the past year to figure out the strengths and weaknesses of using standard measures of competencies and determining new areas that we need to explore. Each of us will bring a perspective from his/her own work and from our collaboration in the network. You will hear from John about the history of how grades have been allocated in schools and get a sense of how changes over time bring about different definitions of competence. This also may be applied to evaluating programs. I will be talking primarily about minority and ethnic families and how many of these issues are even more relevant when we are dealing with them. Deborah will talk about one of the specific projects from the network and how these issues have been incorporated into that project.

Jacquelynne Eccles: I do not specialize in Head Start, nor do I specialize in the period of life before elementary school. My work is focused largely in adolescence, but more recently in middle childhood. I am the chair of the MacArthur network on successful pathways through middle childhood. We focus on how children move through the period from 6 to 12 years of age and then into adolescence. We also look at how their communities, families, schools, and peer groups facilitate successful development, and what poses obstacles to that development. We are interested in understanding what competencies, characteristics, and social supports need to be in place as children approach the age of six to move successfully through the next years.

While we are focused on a particular age group, from 6 to 14, we are also interested in the transition into and out of that age group. The transition to middle childhood is just one window of time in children's lives. They come to that window with experiences and a whole set of life circumstances that either position them well for moving on a successful trajectory through middle childhood or put them at risk for a successful transition.

The MacArthur network is an interdisciplinary network of scholars from the fields of history, sociology, economics, and medicine. We bring together interdisciplinary strengths to think about child development. We spend time thinking about questions like: What is a successful pathway? This means that you have to think about what success is and what a pathway is. How do we think about these concepts theoretically and empirically? What do we want to know about a child, their family, and their social context in order to understand something like a pathway, which means events or experiences tied together over time? We have spent a lot of time trying to come up with a definition of success. What is an indicator of the success of a program? What is the program trying to achieve? Why do we pick certain indicators as opposed to others?

One of the original purposes of Head Start was to get children off to a good head start; that is, position them well when they make the transition into elementary school to continue to be successful and to learn from and cope with various experiences as they move through the elementary school system. What ought to be the competencies that the children bring with them from a Head Start experience? What ought to be the baseline?

Methods for Assessing Low-Income Minority Families

We have had heated discussions. I am going to try to pull together the things that we have agreed upon. These are key features of both characteristics of the children and of their community. From our discussions, we have become acutely aware that it is probably incorrect to define the competencies as existing in the child. One of the strengths of Head Start is that it never focused on the child in isolation, but rather on children, families, and communities. When we think about competencies that put children on a good trajectory or a good pathway, we are really talking about competencies that exist within the child and their entire social network.

Another issue is whether there are good measures for the kinds of variables that are critical to competency. They are going to have to be contextually and culturally defined, not typical standardized measures. An important variable is a sense of agency or efficacy. We have focused on a subset: the agency to learn and the agency to relate to others in multiple worlds. We also realized a need to be sensitive to the fact that children in the United States at this time live in multiple worlds. Part of what they need to succeed is the ability to deal with these multiple worlds and cultures. One needs a sense of efficacy to cope and to control one's own behavior, the feeling that one can trust oneself in settings, a sense that one can get what one needs from others, and, most fundamentally, a belief in a contingent predictable world. One can impact one's own environment, but there must also be a sense of competence that one has the skills that are needed in various environments.

We talked about required domains and valued domains. If a child is going to be in school eight hours a day, there are certain required competencies that they will need in order to be able to elicit positive experiences in that school setting. It is important that they have a sense that they are competent in those domains. However, they also need to have a sense that they are competent in domains that they, their family, and their social network value. That may or may not be the same as the competencies required in their school setting or in their neighborhood setting.

These are characteristics of some required competencies for positive interaction: 1) self-esteem: a strong sense that you are a valuable person; 2) positive motivation: having interests and passions; 3) hopefulness and planfulness: a sense that there is a positive future for them and that they can mobilize their own resources; 4) secure social attachments with key adults and peers; 5) an anchoring value system: the development of a sense of what is important to themselves, their family, and the people around them—the value structure of social responsibility; 6) a positive identity: the beginnings of understanding who they are and their place in the world—gender identity, cultural identity, racial identity; 7) competencies in knowledge: literacy and numeracy skills; 8) reasoning and learning strategies: metacognitive strategies to understand how to operate in a learning environment; 9) social skills and cultural knowledge from multiple worlds: basic information about what is expected in a classroom, on the streets, and at home; and 10) physical health.

There are two that are especially important. What would we want to have in place to buffer a child to move successfully from early childhood into middle childhood? I am going to use the term "social capital" because it is currently a popular term. I am using it loosely to mean advocates, social support networks, safety nets, and connections to valued and needed resources and gateways. As children move from preschool into the elementary school period, one of the things that Head Start is particularly good at is providing or helping families provide this social capital for their children. Any time that you want to measure competencies for children in this age group, you must focus on the impact of an intervention like Head Start, since it provides those resources.

The second is what I call "appropriate positioning," being on the good path. A lot of what is important for children is having them be at the right place where they can get access to the

Methods for Assessing Low-Income Minority Families

right resources. They also need to have the right skills and temperament to be able to take advantage of the opportunities that are available to them and to be able to cope with the kinds of problems or challenges they are going to confront. Head Start can play an important role in helping position children well. It is important that children are in the right classrooms with the right teachers, in the right reading groups, and in the right peer networks, in order to increase the probability that they will continue to have experiences that support positive development as they move through elementary school. The next three speakers are going to be much more concrete and specific about how we have tried to take these ideas and translate them into a research agenda.

John Modell: My presentation today draws upon a variety of observations that I have made from preliminary research. It seems to me that a lot could be gained from studying the history of school marks and marking systems in the United States. I have not done this yet, so these are only scattered observations, methodological reflections that follow from this poorly documented history. These reflections will seem paradoxical, for I will argue that the history of children's school marks indicates a startling lack of sensitivity to the content of these marks as opposed to the form, to educational currents, and to social change. There are some things that I can see as startlingly unchanging in the marks that teachers give children. Researchers like you and me, interested in interventions like Head Start, would be wise to back off from seeking fresh decontextualized ways to conceptualize and measure developmental competencies. Instead, we should seek to understand what—within a given era, school, and classroom—children's marks mean. It seems to me that what children receive, in a given class, in a given year, in a given school, should be understood as an interpretive task, and something that calls for interpretive social science. They should be interpreted in context, within their local setting, and in terms of the characteristics of the children. A "B" does not necessarily mean the same thing for Bob and Jane or Bob in School A, and Bob in School B.

Why is the history of children's school marks so hard to discover? If you look in educational psychology on children's school performance, you will see that around the 1960s, with some notable exceptions like Doris Entwisle, they stopped using school marks as a variable. They lost faith in them because they had learned that they do not measure decontextualized competencies. They seemed idiosyncratic and, thus, not interesting. Therefore, it is very hard to do historical research, gathering together what children's grades or marks meant, from published literature. They meant a bunch of things. Teachers give marks that relate to achievement within a particular curriculum for the A to B range. Most of the variance between C and D has to do with effort or attitude. Teachers in practice simply will not use their marks exclusively to evaluate the relative excellence of the child's academic work in class, whether criterion referenced or norm referenced. They just will not do it. They use grades to motivate and to communicate about attitude. They talk about promise, progress, self-esteem, motivation, cooperativeness, interest, and self-referenced achievement. That is because teachers think that they can accomplish their larger mission, which is to move children along on a good developmental pathway by using marks in this flexible way. The persistence of this tendency on the part of teachers, despite efforts by school specialists in marking and grading to have them adhere to the standard orthodoxy (i.e., marks refer to measurable achievements in the curriculum), is very striking.

There is an important article by the sociologist Robert Merton, written in the early '40s, where he commented on the immense literature on the persistence of political corruption within urban reform. Merton says that we should step back and look at what functions the urban machine serves within cities and how the persistence of corruption may reflect the disequilibrium

Methods for Assessing Low-Income Minority Families

within the particular system. There is an analogy to the persistence of marks having many different meanings in different settings within schools. Marks function as complex communications, a kind of a constrained language, but they are a language that talks about things that go on in the classroom and in the school regarding children's development. Marks are the administrative bureaucratic language of how well children are doing. There may be no other available language that explains why this function seems to persist despite well-intentioned efforts to get rid of it again and again. As a side comment, you may know there is a classic piece from the 1960s by Morton Deutsch, where he attacks marking or rating. The author talks about how there is a parallel between marks and money in a capitalist society. The same thing was written in the 1920s.

There is an ambivalence about whether marking is appropriate at all. However, there are obvious costs when marks are dropped; in particular, children's performance is hard to interpret, and there is no uniform meaning or singular dimension. We should invent decontextualized measures of the competencies in which we are interested. Children are not located in particular settings, but in the great platonic world of development. Yet, do the criteria for achievement in standardized tests come from the nature of things, from the nature of human beings as a species?

Standardized achievement tests measure some common curricular core that actually can be found in schools—in which case the location of achievement in the nature of things disguises its actual location and the current nature of institutions. Marks, at any rate, are honest, or else they measure what they wish actual curricula covered, in which case it is conceivable that some proponents believe that their wisdom about what children ought to be taught rests somehow on eternal principles. However, if they believe this, it is only by virtue of an astonishing arrogance in the face of the history of curricula. I have looked a little into the history of NAEP, our nation's report card. It is a very good standardized achievement test, and I found that its origin, as well as its most recent embodiment, was a wish to introduce something that more closely approached a national curriculum. This wish, however, Washington vigorously fought off so that, at the very minimum, such centralizing goals have to be both compromised and hidden.

It is easy to imagine that there is such a thing as achievement, but I do not think that that belief actually helps formulate useful measures. I think it is the same for development. One of the recurrent themes of the MacArthur research network is the extent to which the history of developmental psychology has wrapped normative prescriptions for how children should grow up in the language and method of science. This can be so subtle as to be unconscious—and yet rhetorically powerful—as in the almost reflexive use of least squares linear regression techniques, however elaborated, that look to central tendencies rather than to dichotomies. The universalism of standardized tests of academic achievement contrasts with school marks in much the same way. A teacher may give a child a better grade rather than a worse grade in the face of that child's achievement in a particular curriculum, because the teacher understands achievement to be part of the overall development of that child. "That particular child is growing up nicely now; the worst thing we can do is to discourage him by saying 'C.'"

I would also make an argument that schools are themselves changing from month to month and year to year, since history also happens in and to schools. I was reading an interesting—and to the end to me—infuriating book by Grant. It is infuriating because he is serious about history. He views the school as really changing, both for external and internal reasons, and yet he hangs onto a static notion of achievement within school. He describes a "middle period," when there was racial turmoil in the school although children's achievement was less. Children's achievement certainly was less in terms of certain things, but at the same time these children withstood and learned from this extraordinary period. To measure achievement uniformly across that whole

Methods for Assessing Low-Income Minority Families

period and not to say this—some children did better, some children did worse in this middle period—not to try to measure that at all seems just plain silly; that is, viewing the school as stable, rather than as an historically changing phenomenon. Therefore, there are costs of decontextualizing. We ought to consider whether, if by focusing on decontextualizing academic achievement test scores and disregarding children's school marks, we are placing ourselves in a better position to understand how children are faring relative to some disguised normative standard we have constructed for them, at the cost of being in a worse position to understand how they are really faring within the highly varied institution in which we have actually placed them—some concrete school and some concrete classroom. We are not measuring their childhood; we are measuring development.

Let us first take I.Q. The Australian psychologist James Flynn has proven to my satisfaction that I.Q. has been markedly and notably rising for half a century in most first-world countries. I have found that the variance does not increase, but there really is this rise. Yet as Flynn points out, it is hard to say that children have been accomplishing more as their added I.Q. rises. Flynn speculates that inasmuch as schools have increasingly organized themselves to employ I.Q. and like scores as differentiators of children's individual ability, they may in the process have increasingly taught generations of children to be smart in the particular way that I.Q.-like tests measure. The question is whether this kind of smartness is of much value outside the institutions organized around this kind of smartness.

Then there is achievement. So far as this hypothesized dimension can be measured, it seems that there is some up and down in the particular dimensions that have been measured. However, I wanted to give you a number here that comes from Hartel and Wohlberg, who have done a meta-analysis based largely on pre-1980 studies. The average correlation between school children's I.Q.s and achievement test scores is about .70, meaning that I.Q. can explain, in a statistical sense, about half of children's academic achievement measured with decontextualized achievement tests.

You have heard the term "grade inflation." That is actually what got me into this in the first place. I was interested in the phenomenon of grade inflation, mentioned in kind of a lamenting way as something that happened along with the general downfall of much of civilization around the 1960s and 1970s. The timing of that is correct, but it neglects the fact that there have been at least two other eras in the past 50 years of grade deflation. In fact, there was a small grade deflation before the inflation that worries us all so much. That is to say, there has been anything but constancy in this particular phenomenon. Studies find an average correlation of .57 relating I.Q. to grades or marks. This means that if I.Q. explains about half of achievement decontextualized, it explains about a third of school marks decontextualized. Is this more or less of a difference between the two than you imagined? Is this bad? Is this good? These are about 30 studies that I found that were decent methodologically. This is my maiden voyage in meta-analysis, where I give you the correlation between I.Q. and school marks. What you see is basically a small sample of school grades and I.Q. being measured in weird ways. What you have is about 50 or 60 years of constancy in the connection between I.Q. and school grades. If you really believe in I.Q. and grades, should they be perfectly correlated or should they be perfectly uncorrelated? How much do we want idiosyncratic things that happen within schools, that happen within children's lives, to be taken into consideration? If we really believe there is such a thing as I.Q., how much should effort count?

In summary, what I am saying is that the meaning of things like this are not interpretable, and history suggests that researchers and others are interpreting concrete moments as if they are

Methods for Assessing Low-Income Minority Families

not happening in particular classrooms to particular children with a particular curricula. Marks must be interpreted in context to tell you something about how the child is doing in school. You must learn what the marks mean as a language in that particular time, in that particular place. When you have done that, you are doing a lot better than using decontextualized achievement measures.

Deborah Stipek: I am going to talk about competencies and ask some fundamental questions. I find, as a researcher and the director of a preschool and elementary school, that we often measure things without giving a lot of thought to some very basic questions about why and what we are measuring, and for what purpose.

Why do we want to measure children's competencies? Obviously, we want to measure them, but there may be different reasons for measuring them. I think it is extremely important that we think about what the purpose may be before we look for the measure. One of our purposes is to persuade. Every person in this room is an advocate for children and cares about equity. We care about the resources in this nation that go to children, especially children who are economically disadvantaged. That is one of the things that Head Start is all about. If we want resources to go to these children, if we want Head Start to continue, and we want other programs that support children and families, then we need to persuade policymakers who have control over the resources. Therefore, we need to measure competencies to be able to make persuasive arguments for these interventions. The kinds of measures that we choose and the way we measure them may be different than if we had another purpose in mind.

Another reason we might measure children's competencies as researchers is to understand what kinds of program qualities and resources seem to lead to the most positive competencies that we are trying to achieve. We know that Head Start programs vary in quality. What are the qualities that make a difference? We may want to measure children's competencies to better understand what those variables are what the qualities are that seem to enhance children's competencies more than others.

The third reason we might want to measure competency is often forgotten among researchers, but sometimes even forgotten among practitioners, and that is to plan. We need to measure children's competencies on a daily basis, systematically and carefully, for program planning, and to be able to figure out what we need to be doing at any moment in time for any particular year. Within any program, on any given day, there are huge variations in what children understand and what their competencies are, regardless of the dimensions on which you are assessing competencies. Only to the degree that we are able to fully understand this variability in children can we develop a day-to-day program that is effective.

ACYF has the responsibility of gathering information on competencies to persuade policymakers. Perhaps university researchers have the responsibility of gathering information about children's competencies to better understand how to enhance them, and program directors and teachers have the responsibility for assessing children's competencies to be able to plan their program. We have probably compartmentalized too much. We need to pursue ways in which these activities overlap. In fact, if information in programs is gathered systematically about those competencies—producing a data set—we might be productive and useful for all three purposes: persuading, understanding, and planning.

The next and very fundamental question is: What competencies should we measure? Jackie quite rightly said that we do not want to consider competencies only in the child. We want to consider them in the program, in the parents, and in the community; that is, in the social context of

Methods for Assessing Low-Income Minority Families

the child. I am going to focus on child competencies: cognitive, social, and physical. We are also concerned about a whole set of competencies that some of us have tried to measure—and not necessarily successfully—which I put in the category of motivational/dispositional competencies. How independently can the child work? Does the child persist when he or she runs into some difficulties? How well can the child regulate his or her emotions, such as anger or sadness? What are the child's perceptions of competencies that we think are important?

Another question is—and this one we really do not think enough about—for whatever purpose we want to measure children's competencies, who decides what we are going to measure? Government and experts have certain perceptions of what is important to measure and shift what we think is important. John told us that there are historical changes in what we think is important. Program administrators have some sense of what is important to measure in children; parents have their own perceptions.

I want to share a couple of anecdotes from my experiences at the Laboratory School that have made me more sensitive to the importance of considering parents' points of view regarding children's competencies. What we have found is that what teachers and administrators value is quite different from what parents value. I will give you a couple of examples. We have a bilingual program, because we have a substantial number of children who are not proficient in English. As a progressive school, there is a very strong commitment to maintaining children's native language. Therefore, we have many assessments of children's competencies in Spanish. When the Spanish-speaking parents came in for their parent-teacher conferences, they wanted to know what their child's English competencies were. Our goals and our concerns clearly were not connected well with what the parents' concerns were. In fact, many of the Spanish-speaking parents were not at all interested in their children's competency in Spanish, since they spoke Spanish in their homes.

We also have situations where the teacher in an interview with a parent will say something like, "Well, let me show you how creative Juan has been in the stories that he has been dictating to us." The mother asks if Juan is being a good boy, and the teacher says, "Oh, look at the science experiment that he did. He was so creative in the way he manipulated the materials." The mother says again, "But is Juan being a good boy?" There is no documentation of whether Juan is being a good boy. The teacher will come up with some kind of answer to her question, but it is not something that we focused upon. However, it was something that parents were very concerned about. We have learned in our practical experience that we need to consider parents' points of view in choosing what we assess on a regular basis so that we are prepared to respond to them about what we are seeing and what is important to them. We find that what we assess tends to direct our attention and what we emphasize in the instructional program.

We were concerned that focusing on achievement tests would drive the curriculum. The same thing happens, no matter what the nature of the assessment is. Even when developing portfolios, what you assess tends to drive or be a force in what you implement in your programs. Therefore, you can see how important those assessment decisions are. They are the ones that have a major impact on the nature of the program and what you are actually doing.

The last question is: How do we measure competencies? When we talk about competencies, we tend to think of getting a test—sitting the children down and giving them questions. What I would like to propose is that we think much more broadly. We are a long way from assessing even basic cognitive competencies in children, and we need to think more about that as researchers, as people who are trying to persuade policymakers, and certainly as people who are trying to plan appropriate programs for children. Sam Meisels, for example, has done some won-

Methods for Assessing Low-Income Minority Families

derful work where he has developed materials for teachers of very young children so that assessments of children may be made in their natural context. When teachers use these kinds of materials, they find that they cannot make the assessments in the natural context because the children are not being given opportunities to demonstrate those competencies, given the way the program is currently set up.

I will give you an example from our school. The principal simply asked the teachers of four year olds, "What do your children know about reading? What are their competencies related to reading? Do they know that you read from left to right? Do they know that those scratches on the page represents sounds, which represent words? Do they understand that there is meaning associated with text?" These seemed like a reasonable questions. Certainly, if you care about children's literacy skills, and if you want to plan a program that is going to support those skills, you should know what your children know. When the teachers went back to the classroom, lo and behold, they found that not only did they not know, but they did not have an opportunity to learn because of the way they organized their literacy program. The program always entailed the teacher reading to the children. We had to buy books that were pre-primer readers for the teachers to be able to figure out whether their children had any basic reading skills. They had to change their instructional program to provide opportunities for children to give some feedback. Now, when they read to children, they might turn the book around and ask the child questions. They began reading individually, with children and asking them questions in order to figure out what the children's reading skills were. Some of the children in the program had some fairly advanced reading skills that the teachers were not aware of.

This literacy assessment essentially drove a whole new way of interacting with children around literacy materials. It had a profoundly positive effect on our literacy program. I want to go back to the question of what we measure and make one simple point. There has been a tremendous reluctance among people in Head Start—I think among preschool teachers, or anyone who has anything to do with young children—to be concerned about, to stress, and to focus on cognitive skills. It is almost a dirty word. There are reasons why we are reluctant to think about basic skills, to assess them, and to think about how our programs are facilitating them. One reason is that we got burned. We used I.Q. for a number of years, and it turned out not to be very responsive to the kinds of interventions that we provided. We were also concerned because cognitive skills for many were associated with drill and practice. If I go to a Head Start center and I ask what the instructional program is and how it is facilitating children's cognitive skills, I get a lecture. "We do not focus on cognitive skills here because it will damage their self-esteem and because we do not want to do worksheets that will ruin children forever."

When I do research on children's competencies, I use a very simple basic skills test to gauge the differences between disadvantaged children and their middle-class counterparts. Whether using creative, authentic measures or standardized measures, there are huge gaps between children who are economically disadvantaged and those who are not. It doesn't matter whether or not they had Head Start, or whether or not they had the advantage of any kind of intervention program. Middle-class children in our studies, on average at the age of four, have scores on virtually any cognitive test that are higher than disadvantaged children at the age of five. The children that concern us most are starting school with a huge cognitive disadvantage. I think that we are doing them a disservice by not assessing their cognitive competencies. I am not saying that we have to use standardized basic skills measures. We need to develop more authentic assessments that are systematic and that will persuade policymakers. We have an incredible amount of work to do to be able to do this.

Methods for Assessing Low-Income Minority Families

I urge you to rethink your anxiety about being concerned about children's competencies because they are important, because the children we are concerned about are starting school at a tremendous disadvantage, and because worrying about cognitive competencies does not mean the same thing as giving worksheets. There are lots of ways to facilitate competencies. We need to be creative.

Cynthia Garcia-Coll: I am going to present a slant on how to evaluate or research a prevention or intervention program such as Head Start, given that there are so many minority children in these programs. Minority children are over-represented among the poor in this country, and when we are dealing with competencies and evaluations, we are dealing with a lot of minority children. One of the problems that we have is this: so-called standard measures of competencies are using "successful" as defined with indices that have been conceptualized, developed, standardized, and validated on White, middle-class populations. How much do we believe in diversity and how much do we believe in many pathways and many developmental outcomes as something that we strive for in a pluralistic society? At the same time, there are some basic skills we want everyone to have.

I reviewed the discussions in the network, as Jackie did, and I pulled out other principles that I felt were interesting. The first principle is that we need to use multiple indices of any competence. You must remember that we are a multidisciplinary group that deals with sociological, anthropological, historical, psychological, educational methodology. What we are saying is that we need to have different ways of thinking about and assessing the multiple indices of cognitive development, self-esteem, or social-emotional development. Direct observation gives you just a slice of the pie. Talking to the parents and asking them about their child's competence gives you another piece. Looking at them in a playground interacting with peers gives you another part. Looking at them in their family environment gives you yet another piece. The notion of multiple indices of competence is a must, even if you are only looking at cognitive development.

The second principle is that multiple domains are very important. It is primarily because we think that children develop as a whole, even if we conceptualize their competencies in different contexts, like in school or with their family. If we use only one developmental outcome, we might be missing positive and negative effects in other areas that may get in the way of positive developmental outcomes later on.

Right now we are at an historical point where our theories of development and the way that we conceptualize development are so much more advanced than our tools. We must develop tools that reflect the ways that we now think about children and development. That is our present task. Multiple indices give you a better handle on a particular phenomenon, such as literacy. If you look at it from different perspectives, it gives you a better way of measuring what is going on. In addition, some measures are more sensitive than others and will provide complementary information. For example, if you are looking at the self-esteem of the child in a school context, it is very different than in a family or peer context. It becomes even more important to deal with multiple indices when working with children of color because most of the measures are standardized on and geared toward White, middle-class populations. If you give only one measure and a minority child fails to do well on it, there is an open question of how much of the failure is in the measure and how much is in the child. The only way that you can be more sure is to use multiple measures. Another issue is that this standardization and validation might not be capturing the strength of these children. Around two years of age, we start seeing the discrepancy between disadvantaged and advantaged.

Methods for Assessing Low-Income Minority Families

That brings up the question: Where are they succeeding? What strengths do they have that they are bringing into school? How can we capitalize on those strengths to bolster the other ones? The notion of a deficit on a particular measure when we are doing evaluation is not necessarily a deficit in the child's capacity, but a question mark. What else is going on and how much can we tap into it?

Multiple domains involve developmental, interrelated, hierarchical feedback loops. If you do better in reading in school, maybe your self-concept will be better, and then your peer relations will be better. It is also important to measure multiple domains, because there may be both positive and negative results in different domains. It might be, for example, that you can raise a child's literacy skills in a particular area, using books that do not represent their day-to-day experience. What you find is that these children might be better readers, but they might be disengaging from school because their own experience is not there. We now know that the experience in their school and their family have to be integrated.

For minority children it is even more crucial to deal with context in measuring competencies and evaluating programs, because there is a discontinuity in a lot of areas between cultural demands of home and school. When you are trying to figure out what a child is acquiring, you might find he or she is acquiring a skill in a particular context but not making the generalization to another context. Competing expressions of competence may be fostering different outcomes, such as being a good boy versus being creative. Being creative implies that you are "loose," perhaps not following directions, doing your own thing. Being a good boy is following directions, sitting, not venturing to explore your creativity, perhaps even squelching it. Part of what we need to teach children is to deal with multiple worlds, and it is sometimes multiple worlds that are competing and are actually contradicting each other.

In conclusion, if you are going to be evaluating, one of the main things to ask is whether the measures are valid and valuable with a particular sample. Most of the time they are not. Therefore, the question is what do you do next? What we need to do is measure multiple indices of anything that you are looking at, try to measure as many domains as possible, and take context into account. That may mean using some standard measures, and then using some measures that you develop yourself. These principles then should provide the decision rules for evaluation research. It is not necessarily all that we need and have to do to respond to funders or administrators, but it is closer to what we think may be going on with children. I would really like to leave you with a note of caution about interpreting the lack of successful performance with these minority populations. I believe it is an open question of exactly what is going on, and, when you find it, the next question is why.

Gina Ruther: I was asked to present a practitioner's point of view, which is very easy, having been in Head Start for the past 20 years in various capacities, starting out in education. When I looked at the title of this presentation, I was ready for battle—being a Head Start practitioner and having lived through fade-out, cognitive gains, and the ways that we believe our funding would be affected, and the ways we plan programs. I was pleasantly refreshed to hear—Cynthia said this; I did not—that researchers are finally catching up to us. I would not say that about them. I do not know enough researchers or enough about the research world other than to read about research results and try to make some sense out of them in order to plan a program.

I have a few reactions and then a couple of challenges. I know that in the early childhood world, and particularly in Head Start, we have come from a point of fear and mistrust of measurement. For one thing, it has been solely focused on cognitive measurement in the past. Another

Methods for Assessing Low-Income Minority Families

reason is because of fade-out and because of the way that cognitive gains have been used to evaluate programs. For 30 years, Head Start has been a holistic program. Measurement is out of sync with the way that we think about children and families and the way we implement programs. Developmental measurement has not helped us work within our programs. We are mandated to do it, but how we use it varies a lot. The things that were said today were refreshing to me, in that we need to look at a breadth of competencies and not only the competencies within the child. We need to take risk factors and social context into account. This is not news to us in Head Start. We have been doing that all along. However, we have had fragmented measures. We do a family needs assessment. We do mental health behavioral checklists. We do developmental checklists. How do we effectively use all these things to plan our programs? The reality is that what we are measuring in a program is process. Do you have this form in this file, and is it signed and dated, and do you have a plan? The questions are not about how many social services have been delivered, not about quality, not about the content, and not where you have brought particular families. What many of us know we are unable to put together ourselves: the fit between research, results, funding decisions, and program development.

As a practitioner, I do not disagree with most of the things that were said here today. We definitely need to view things in context. We need to use a variety of strategies. We know we find out a lot of different things about children and families in a lot of different ways. That is why we do home visits and interviews, and so forth. I believe that only in those ways can the results of measurement be useful. What is important to me as a practitioner is that the results of the measurement are useful, not that I do an assessment because it is mandated that I do it, and that I put it away until it is time for the posttest. Nor do I do an assessment and use it as public school teachers often do, as a grading or teaching tool. It has to be useful in a holistic way, and there are several issues left for measurement in order for it to be useful to us in the field.

The level of caregiver/teaching staff competence in all early childhood programs also is an issue. Educational background—does it make a difference? Does a CDA operate differently than a B.A. or an M.A.? If so, is it due to an innate ability that I have seen in teachers who had little or no education but naturally know what to do, or is it the result of their education? Caregiver interaction with children we know is critical to children's development. Therefore, it would seem that their performance is critical. If a caregiver does have a degree, what have they learned? Is there a difference in the higher education institutions between early childhood and elementary tracts?

Communicating results to parents—how do we use the results of an assessment with parents? Until we know what risk factors actually affect developmental achievement, how can we help parents understand? Then how do we translate that to parents? There are many vague things that are discussed about socioeconomic status, substance abuse, caregiver education, parent education, and parent knowledge of child development. Do we really know enough? If a parent has no knowledge of child development, what behaviors can we expect to see? What will be the result for the child?

There is one challenge I would put to researchers. As practitioners, we have got to get comfortable with assessment. We must because of the three reasons that Deborah talked about earlier. We have to sell ourselves, and we know that, and we have to have some measures, some tangibles. That is probably why the OSPRI looks like it does. If you have the right number of forms in the file, then that is measurable. We have got to get so comfortable with developmental assessment that we embrace all of this and assist researchers, form partnerships so that they can hear from us: This is what we need to know, and this is what we know that we can share with you. We have got to be able to persuade. That information is critical for planning effective programs, and

we are in a day when we cannot afford not to plan effective and quality programs. We have to use assessment, and we have to speak up when the assessment does not get us what we need.

There is one other issue that I still see hanging out there, and that is the link with the public schools. I think that we still send our children into institutions that are cognitively oriented and grading in a very different way than we do. We do not send marks home, and our assessments are developmentally driven. It is up to us as practitioners to translate our assessment for public school use, and researchers can help us with this.

Audience Questions and Comments

Question/Comment: I am reminded of a state legislature that said that what we really need is a good paper and pencil test for reading for Head Start children. We need to be accountable for a number of reasons; legislators are asking us for that. The question is: For what purpose are we assessing? Are we assessing for children's sakes? We all certainly care enough about children that we want to see them make progress in our programs. Are we assessing to compare ourselves to other programs? Probably also that. So there are two different kinds of measures that we are really looking at: something that is individualized for children, in which case we are going to want multiple measures of what will be expected in the course of a year, as well as something a little more standardized to measure program quality. Is it really that hard to develop appropriate assessment tools?

Cynthia Garcia-Coll: One of the problems is generalizability. How do you make the measures generalize to the larger population so that your results are replicable and, at the same time, meet the needs of a particular community? That is the tension that we are dealing with.

Comment: I am surprised that you have not mentioned the importance of assessing learning styles. I would like to assess learning styles so that as I assess children's achievement, I can control for it as a covariant. Hopefully, I can also assess whether the curriculum was administered in a way that matches those learning styles. The focus on individual differences and differences between ethnic groups is important, but if we also assessed learning styles in those groups and whether the curriculum matches those, the evaluations would be more reliable and much more pertinent than the kind of outcome research that we have been seeing.

Jacquelynne Eccles: I am actually going to argue against that, just to be provocative. I have never seen research that I felt made a convincing or compelling argument that this match between curriculum and learning style was meaningful or productive for children. There is another way of addressing difference. This is not to say that children do not have varying ways of learning, but what I would recommend is for teachers to be sensitized to children's learning styles. One of the things that Head Start can do, or any preschool program can do, is to have a program that is open ended and varied enough for teachers to use multiple ways of presenting information. They may present it verbally, with overheads, or with materials. Those children who have different ways of understanding the information have an opportunity to get it the most effective way for them. Then the teacher should use multiple ways of assessing children. Those children who articulate well are able to provide the teacher with information about what they understand and what they know. For example, in mathematics, some children are better in drawing designs to represent their knowl-

Methods for Assessing Low-Income Minority Families

edge, others are better at making calculations, and others are better at verbally explaining their understandings. Therefore, the implication of learning styles is that you have to have diversity in the instructional program and diversity in the assessment techniques with any group of children.

You are making an assumption that learning styles are somehow stable. We do not know that that is true. Styles are, in fact, learned. If we reify learning styles, then they become like the I.Q. measure, somehow existing independent of the environment in which the child is growing up. I do not believe that is the case. We need to know something about the way that children approach different tasks. We also need to know ways that we can evaluate a program's ability to teach them to approach tasks in a variety of ways.

Question/Comment: What is your definition of a valid measure? The emphasis has always been on the reliability and validity of the instrument and its predictive value across groups. From what we have heard here, we need to go beyond that.

Cynthia Garcia-Coll: There is the notion of external validity, which is the one that I was referring to the most; that is, if a child knows something, they can demonstrate it by the test that you are giving to them, or, if they fail to do something in any context, they will be failing because their failure in performance is failure in ability. I was referring to external validity more than the psychometric properties of an instrument—its factor structure.

Comment: I do not think we have the faintest idea what validity is. You need to go back to the question that each of us raised, which is: What do we think we are using the test for? You can then figure out whether or not it is, in fact, measuring what we think we are measuring. Usually we do it mindlessly. We use the test because it is there, not because we think it is measuring what we think we want to measure.

I would like to take us back to another issue that is absolutely critical, the link between Head Start and the schools. If we are thinking about providing children and families with the kinds of experiences that will not fade, that will pay off as the children move through the next phases of their lives, we need to think seriously about the issue of positioning. What is it about the experiences in Head Start that either position children and families well for the gains to be maintained, and what is it that is accounting for this not happening? Then we must try to put in place measures that will pick up whatever is facilitating this positioning, and those will become part of the program. That necessitates working with elementary schools. In fact, when we talk about Head Start being part of the community, part of that community is the elementary school that the children are going to move into, and a stronger interface between those two institutions is essential.

Richard Gonzales: I am the Head Start director in New York City. I am really pleased that we are bringing together researchers, policymakers, and Head Start people to talk. What may be happening is that researchers may actually be making progress in understanding Head Start better. I am not sure if Head Start is making any progress in understanding research better. We find in our programs, more and more, that we do not have a good understanding of research terminology and concepts. And so as we begin to look at who determines the measures and who determines what to ask for, I find that we are in strong positions to make those kinds of decisions. One of the other things that I am seeking and asking is that as researchers look to make connections with Head Start programs, that shared learning is taking place in both worlds so that we can be more effec-

Methods for Assessing Low-Income Minority Families

tive in what we are doing. In those programs where research has begun to take place, a lot of times it is the administrator or the few staff members who understand the importance of the research who take the lead, but the staff and parents do not really understand all the elements. They do not know how to make the connection between the various things that they do and what the research says, how to translate it into action. I am commenting on the importance for us in the Head Start community to connect to a better understanding of what research is about and to play a significant role in directing where that research goes and how to use the results.

John Modell: There was a note in Gina's comments that I think is worth underlining, which is that, in part, measurement as a research tool is also a tool for controlling. Therefore, we are not simply talking about intellectual or even institutional deficiencies on the part of Head Start; rather, there is an ongoing struggle for power. Going back to my issue on marking, teachers successfully resist schemes that would cause them to act differently in their classrooms from the way that they choose to act. So what you say is right. You need power-sharing. Power is a very important term in what you are talking about. It is only at that point that there really will be the mutuality that you are seeking.

Question: It seems to me that I have been hearing over and over again the argument for qualitative research, and you are talking about quantitative research. Are you saying that it is qualitative research that will lead to shared power and methods that will help make it a useful tool? My sense is that when we say qualitative, people become very nervous because it will not give you the arguments that you perceive yourself as needing in an antagonistic, budget-conscious environment.

Cynthia Garcia-Coll: A lot of our discussions within the network have been on how to link qualitative and quantitative methods and think of them more on a continuum. We want to try to develop measures that involve both sets of methodologies to provide more insight, flexibility, and, at the same time, quantitative results.

Comment: We are, as you say, a long way from figuring out how to use qualitative information, although, ironically, it is usually qualitative data, often the case study, that is presented at legislative hearings. We have not figured out, in the fields of psychology and education, how to powerfully use the case study approach, although frankly, I think most policymakers make their decisions based on that. It is the nephew down the street, so to speak. For purposes of understanding and planning our programs, we are better at using qualitative information on a daily basis to figure out what to do next. In fact, teachers do not use quantitative information very much. There may be ways that we can look systematically at how teachers are doing that and figure out how to move from the day-to-day qualitative data gathering that practitioners do to the research level.

John Modell: I was just going to point out that there is nothing inherently more "sharing" about qualitative approaches than about quantitative ones. For instance, anthropology's roots were in the control of natives a hundred years ago. It was in that setting that ethnographic techniques were developed. At the same time, the roots of positivist, quantitative social research in England were reformist and anti-the conventional power structure. It has to do in part with the way that the social sciences are currently organized, and the interlocking connection between standard

Methods for Assessing Low-Income Minority Families

social science terminology, methodology, conceptualization, and large-scale, trans-local bureaucracies. We will only get the kind of qualitative investigation that you are talking about as the whole thing begins to unravel, which it may well be doing right now.

■ Issues in Developmental Research with Children and Families of Diverse Backgrounds

Chair: Cynthia Garcia-Coll

Discussant: Juanita Santana

Presenters: Cynthia Garcia-Coll, Diane Scott-Jones, Catherine Cooper, Jacquelynne Eccles

Jacquelynne Eccles: I am Chair of the MacArthur Foundation Network on Successful Pathways through Middle Childhood and a member of the Successful Adolescents Network of MacArthur, as well. This is an interdisciplinary group of scholars from multiple universities. We are charged to create new knowledge about approaches to studying human development, particularly during the age range from 4 to 15. Our interest in studying race and ethnicity stems from several reasons: 1) because of the persistence of inequality across various groups in this country; 2) because of increasing ethnically linked divisions and hostility in this country; 3) because we are a diverse and a multicultural country; and 4) because we have a basic concern with how children make sense of who they are and how they fit into the larger social context that surrounds them.

I want to begin by making clear some basic assumptions that have been guiding our work. First, we do not believe that race is a fundamentally biological phenomenon. Many of you may remember when you were trained in school that people talked about three racial groups in the world. That is no longer believed by either geneticists, biologists, or anthropologists. In fact, there is as much diversity within each of those three groups genetically and morphologically as there is between those groups. Nonetheless, race is a critical, historical, social, political, and psychological phenomenon.

We have become interested in the more fundamental process of racialization—the extent to which groupings or kinds come to be considered as biologically based or having some essence to them beyond an arbitrary classification system. Once this happens, we know that it fundamentally changes the way groups interact with each other, and it fundamentally affects both human development and interactions in profound but little understood ways. That is a task that we have set ourselves to try to understand: how is it that ethnicity ends up affecting human development? I will show you three approaches that are guiding some of the work that we are using.

The first basic approach is to look at whether there are differing experiences linked to one's ethnicity. Does one's ethnicity essentially change the probability of various types of experiences or life situations? This is the approach that demographers, economists, and sociologists often take, where they essentially try to come up with a way of classifying groups of individuals and then linking those classification systems to things like family income, religious experiences, or educational experiences of the neighborhoods that you live in. Essentially, how does your group classification end up changing the kinds of experiences you are likely to have across your lifetime? This is directly linked to issues of discrimination and prejudice, segregation, integration, and equal opportunities.

The second way one can study ethnicity is ethnicity as a social belief system. This is more the way the sociologists and anthropologists would tend to study this set of categories. You would look at questions like: Does ethnicity affect one's perception of various experiences? Is it an organizing category for one's view of the world and one's experiences in the world? What is the content of the ethnic group image, schema, or stereotype? Does one's ethnicity affect the goals and values one has for oneself and one's children? Is one conscious of this link? Is identity linked to goals and values, aspirations, self-perceptions of one's children's competencies, one's sense of efficacy, and so forth at a descriptive level? Even more fundamentally, is it core to one's own

Methods for Assessing Low-Income Minority Families

identity? Another set of questions is: How is ethnicity encoded in the self system? Is it an organizing category for one's view of oneself? Is it an organizing motivator for behavior and plans? How does one deal with multiple and possibly competing identities and conflicting messages about what being a particular ethnicity means? We now live in a world where individuals may be members of more than one ethnic group or may think of themselves as being multiethnic. That poses interesting questions about how one integrates those various identities.

The third perspective is to identify ethnicity as a developmental phenomenon. This is how a developmental psychologist would approach the question. How does the impact of one's ethnicity, for example, change with age? Does one's sense of ethnicity change over age? Does the content change? Does the salience change? Does the sense of being stigmatized or privileged change? Is there ethnic identity transcendence, and, if so, what is it? Does the relative salience of various identities change over time?

Finally, what accounts for the systematic developmental changes and for individual differences at any one age? These are the questions that the MacArthur Network is going to be addressing over the next six years. The other members of this group will give you more details about specific studies and about the kinds of methodological issues we have had to deal with as we have attempted to address some of these questions.

Cynthia Garcia-Coll: I want to take the opportunity to read a letter that I received this morning. It says: "Dear Mrs. Garcia-Coll, I am writing to you as a center director for Head Start, as well as a concerned parent and an early childhood professional. I want to remind you of an increasing number of Head Start children and families who are not acknowledged by Head Start in our society at large. This growing population is of multiracial children and families. Over the years, I had regretted enrolling multiracial Head Start children and having to misidentify them on forms that do not include a multiracial option. This must end. Multiracial families and children are literally changing the face of this nation. It is time that Head Start acknowledges this and begins to recognize the multiracial families and their unique needs. I am requesting that you address this issue at the Research Conference and challenge early childhood professionals to meet the needs of all of our children."

I was amazed that somebody would take the time to write a letter to be shared with you at this time. It pointed out to me the significance of these issues. What I want to do now is share with you the way that we have been thinking about categories.

What the network has done is sit with the notion of categories, and how categories have been used for services, for classifying all of us in research projects. Should we toss them out? Should we review them? What are the pros and cons of these categories? These categories are important not only for demographic changes, but also because children and families own these categories to a certain extent, and the categories mean something for them and for service providers. If you are called multiracial, African-American, Latino, or whatever else, that has some connotations for you, your family, and your own development.

First, why should we be measuring these categories? There was a recent article in *Child Development* by Entwisle and Stone that examined how we should precisely define categories to identify people. It is important for us to acknowledge these categories and include them, because they are central to the understanding of human development. It is important for us in studies and in Head Start to be able to identify people, because then we can compare notes of what is happening with this program or that research. It also does not assume that all of us are the same. To a certain extent, it is not that the categories are bad. The question is: What do you do with those

Methods for Assessing Low-Income Minority Families

categories? The problem is that it contributes to thinking about people as part of this immutable thing that we do not think works.

What is the problem with what we called the categorical approach? It basically treats race, ethnicity, and social class as bounded. It is absolute and independent. There is a notion that these categories work if you compare Puerto Ricans and Whites. Then there is a notion that every single member of those categories behaves in this particular way. It also fails to recognize that there is a social construction, that it reflects history, geographic location, and culture, that it is not only race, but also ethnicity and language. It is much more of a process, and the notion and use of categories disregards to a certain extent all those processes that are important.

Another aspect is the notion that it disregards variability. It also disregards processes, both similarities and differences. It is the notion of comparing groups. There has always been a sense that we want to look for differences. To a certain extent, one of the most interesting things is how many commonalities we have in processes. The categorical approach also brings an implicit hierarchy. There is always a sense that if you are comparing two groups, one of them should be better than the other. There is this perpetuation of the inferior and superior stereotype.

We are not trying to say "Throw the categories away." The categories are important because, to a certain extent, they give us a window into some important processes. However, we have to reconceptualize them. We have to think that there is heterogeneity within categories and that the categories have fuzzy boundaries. There is fluidity in that I, for example, take a plane, and I become a woman of color in this country, versus in Puerto Rico, I am considered White. If we start thinking about multiracial children, there is a fluidity of change over time that makes it important to figure out how children become aware of these categories. How do they accept and change with those changes?

These are complex issues. To be Puerto Rican is not something that is uniform for all of us. The point is to extract that complexity, which comes by the fact that I am not only Puerto Rican, but I am middle class, a woman, and of a certain generation. There is a certain sense that all of these categories become joined. They change over time, and the context influences a lot. There is a sense of saliency, of ethnicity, coming out because the context makes you aware of things that you were not aware of before. These are basically social constructions. They do have some biological descents, but this is more of a continuum than something that is completely different. What we are saying is not to throw the categories out, but to study them differently, to think about them differently. Think about them as processes.

Think about how individuals construct or internalize particular things. Work done with preschoolers has told us that they make preferences on dolls from one race to another. However, that does not mean that they feel worse about themselves. What gets internalized from these categories? Also, there is the issue of how people resist these categories. There is the notion of maintaining a sense of self in spite of the fact that the environment is telling you that you are being devalued.

We should study this developmental phenomenon. By three years, children start dealing with gender and racial identity. How do children get a sense of themselves and a sense of how they behave as part of relationships? The categories need to be studied themselves. They have been dramatically changing over time in the United States. It is essential also to get a sense of historically where these categories come from. The more we understand them, hopefully, we will be able to think about them in terms of development. We should strive for precision in the definition, and at the same time, we have to think about them as social constructions. We have to study the processes by which children internalize, by which families make sense for them. We need to

Methods for Assessing Low-Income Minority Families

think about how teachers react to children because of differences in race, ethnicity, and class. We need to think about this also for White populations. This is not only an issue for people of color. This is an issue for all of us.

Diane Scott-Jones: I would like to share with you our thinking on approaches to research with families of color—families of diverse ethnic groups. In our network, we have wanted to understand how diverse families socialize their children, and we want to know how these socialization strategies that parents use are related to successful outcomes in their children. I want to focus not so much on the answers to those questions, because we do not quite have them yet, but on how we go about asking these questions. What assumptions do we bring to the study of families of color? What are the concepts and the measures that we have used when we assess families of color?

As you know, researchers often have excluded families and children of color from their studies. A major exception has been Head Start and other early intervention programs. However, typically, researchers have focused on middle-income, White families, and they have idealized these families, using them to set the standards for child rearing. When families of color have been included in research, the focus typically has been on deficiencies and on problems in these families. As a result, we know far less than we should about successful development in children of color and successful parenting in families of color.

Our network has attempted to respond by studying families of diverse ethnic groups, and we have spent the last year reviewing what we know about families of color. We have had a special interest in the concepts and measures that have been used when we study families of color. It has been a luxury to have the benefit of the entire network and a lot of others' ideas, their criticisms, and their challenges. I will share a few observations from this past year's work.

First, we found that the concept of collectivism and individualism frequently were used to distinguish families of color from White families. There were many general descriptions of African-American families, Latino families, Asian American families, and Native American families that emphasized the importance of the family, or of the ethnic group. These families are said to socialize children toward group goals, and this is called collectivism. Collectivism is defined as a social pattern where individuals are closely linked to one another. Collectivism is contrasted with individualism. Individualism is said to characterize White families. Individualism is defined as individuals primarily motivated by their own needs and their own preferences. In the literature, individualism and collectivism are seen as basic and opposing cultural scripts. They are seen as guiding the lives of families and providing an orientation for the way they socialize their children. However, if we review the literature, we recognize that this contrast is too stark in its present form. The concepts are oversimplified when they are applied to family socialization in children of color. In ethnic families, the idea of a group orientation, on the one hand, is inappropriately placed in opposition to the idea of individual responsibility and achievement, on the other hand. Some scholars do describe collectivism of families of color in a positive manner. However, in some instances, individualism is seen as more desirable than collectivism, as more fundamentally American. When we make comparisons, we typically do not just leave them as comparisons. We assume a hierarchy with one dimension being more important or better than another.

Why does it matter whether you see families as individualistic or collectivistic? It matters because when researchers adopt these broad and sweeping ways of thinking about families as being fundamentally different, then they may exaggerate differences that exist between White families and families of color, and they may overlook the many commonalities that exist among

families. As we reflected on these broad differences that are said to distinguish families, we came to prefer a different way of thinking about them, and that is the concept of ensembled individualism. Ensembled individualism places the individual always in the context of a group. We came to think of this way as the ideal way to socialize children within families.

This idea of ensemble individualism comes from the works of Edward Sampson. Sampson refers to the usual formulation of individualism as self-contained individualism. Self-contained individualism is characterized by having a boundary between oneself and others that is firm and sharp. Ensembled individualism, in contrast, is defined by a conception of self that includes others, and the boundary between yourself and others who are important to you is not as sharp and as strict as in other conceptualizations of individualism.

Sampson also speaks of social individuality. You become an independent individual, but you always remain part of a family, part of a social group. In American psychology, ensembled individualism may be mistakenly assumed to be immature or dependent or even pathological. However, there are many ways in American psychology that we do acknowledge that people do not genuinely become independent of one another. You become an individual, but you never lose your connectiveness to your family and to others in your social group. Self-contained individualism, more generally, in American psychology is assumed to be the only way that you achieve what we consider core American values of responsibility, freedom, and achievement. However, in Sampson's work, he challenges the idea that self-contained individualism is fundamental and beneficial. Instead, Sampson asserts—and we came to agree—that a psychology of ensembled individualism is more likely to lead to what we value as Americans.

The next thing we thought about was if researchers approach families of color as being different in fundamental ways from White families, then you might think that when studies are designed they would use different concepts and measures for families of color. Yet, that has not happened at all. In fact, researchers who begin assuming broad differences then proceed to use the very same concepts and measures for all families. They give little thought as to whether these concepts and measures are appropriate for the specific families being studied.

To illustrate, I will use Diana Baumrind's seminal work on parenting styles, which was begun in the mid-1960s. Her well known typology of parenting includes authoritative parenting, in contrast to authoritarian and permissive parenting, as the ideal parenting style. This style results in positive developmental outcomes for children. Baumrind's work began with predominantly White, middle-income families and used a variety of methodologies. Early on, Baumrind, in a 1972 article, noted an important exception to her findings. She noted that in the 16 African-American families that were in her study, there was authoritarian parenting, but unlike in the White families, their authoritarian parenting was associated with good developmental outcomes. From the beginning of her work, Baumrind cautioned that her typology might not be appropriate for all ethnic groups. Baumrind's wariness about generalizing appears to have been ignored as other researchers used her typology. You would expect follow-up research on authoritarian parenting in African-American families so that you could understand what it means in those families, and then refine the original construct to incorporate African-American families' circumstances and experiences. However, that has not occurred for the most part. Instead, researchers have documented that African-American, Asian-American, and Latino families are more likely to be authoritarian than White families.

There have been some efforts to revise parenting constructs to fit the lives of families of color. For example, Chinese-American families have been studied by Ruth Chow. Chow uses the notion of training as the concept that arises from Chinese culture. She says that is more important

Methods for Assessing Low-Income Minority Families

in Chinese families than the idea of authoritarianism. Training refers to having demanding child-rearing practices, but in the context of maternal devotion and sacrifice. It looks like authoritarian parenting, but in their culture it is not. Also, Lau and Chung, when they looked at parental control, found that it is not always negative in Chinese-American families. Instead, control included elements of organization and order. The concepts are different in various families. However, we have not studied this much.

One thing that we uncovered in our review was that some of the problems of studying families of color have been related to whether we use qualitative methods or quantitative methods. It is the case that in some quantitative research, the child of the family becomes a data point in a large data set. The researcher may have no knowledge of families or children of color that comes from sharing or being a part of their particular sociocultural background. When researchers seek explanations for their findings, they turn to stereotypes, or they create fanciful accounts of what is happening in these families because they have nothing else to draw upon.

In our review, we found that multiple methods are needed. It is not just qualitative or quantitative research, but a more important distinction was whether the researcher could somehow incorporate the perspective of the families being studied. We preferred thinking of a distinction between emick and ettick perspectives, perspectives that arise from a particular cultural or ethnic group, versus perspectives that are trying to cut across those groups and create universal explanations. We found many examples of quantitative research where the researchers did make great efforts to try to capture the perspectives of the persons being studied. One thing that we concluded is that any of this research can be problem oriented or deficit oriented. An example of how you can change your perspective easily is the study by Harriette McAdoo and Tom Mustard from the National Longitudinal Survey of Youth. They looked at six- to nine-year-old African-American children in that sample. They initially created a risk index. However, they turned around and looked at what they called an advantage index. It is a small change but an important one.

The ethnic separateness in our society is a grave impediment to the research process. Ed Zigler, in his opening talk, quoted George Miller, who admonished us to give psychology away. We often think of giving away our results. I would like us to think about giving psychology away much earlier in the research process, when we are developing basic concepts, the assumptions that guide us in our work, the measures to be used. It is there that we need to give psychology away and make greater connections with practitioners and with the communities that we study. It is only by involving others in the research process from the beginning to the end that we will be able to create better research with families of color.

Catherine Cooper: I will be talking about something we started to call intergenerational community partnerships among researchers, practitioners, and policymakers. A focus that we have that emphasizes themes of developmental pathways is to strengthen links and diversity along what many people are starting to call the academic pipeline from Head Start through schooling and on to higher education. I would like to focus on three key ideas. First, I would like to give you an introduction to one of the projects in our network, which we call the MacArthur California Childhoods Project. Second, I would like to talk to you about a framework we are developing. It is what we call an intergenerational pathway across context, including families, schools, community-based organizations—including Head Start—work, and also peer groups and peer relationships. Third, I would like to give a case-study example of a project that we have been doing in central California as an example of an intergenerational community partnership.

Methods for Assessing Low-Income Minority Families

The MacArthur Network has as its overall goal a concern that so many children and families in ethnically diverse communities across the country begin school feeling optimistic about the future, but in only a few short years, their bright aspirations for success begin to fade. Middle childhood is a time when children's paths of life begin to take shape, as they think and act in ways that include their families, but also go beyond their families to school, to the street, to churches or other neighborhood organizations, to peers, and to the media. As children navigate across these different contexts or worlds, their ability to do this begins to become linked with their capacity to think about the future, their grades at school, and their sense of personal identity. At this point, we know so little about this process of navigation that we decided to design a project to look at these issues.

The four organizing questions of our project thread through many of the ideas that you have already heard. First, what are the multiple contexts or worlds of childhood in children's everyday lives? Second, how do children, their parents, teachers, and others in their lives, including siblings, community members, and neighbors, understand these varying areas of children's lives? Third, how do children themselves learn to navigate and move across these different worlds? Fourth, how do factors that we might think of as social categories involving ethnicity, immigration, social class, gender, "race," and other social categories, including issues of disability, become involved in children's experiences moving across their worlds? How are these involved in defining their sense of identity and also of competence as they move from world to world? We have already heard argued that these social categories often come in pairs, whether it is first/second generation, African American/White, girl/boy.

A pair I would like to put on the table in our discussion is good and bad. We hear talk about which is the good one and which is the bad one. We see this coming up even more strongly in middle childhood, when children themselves begin to be more skilled in thinking about social comparisons. For example, we take one eight-year-old girl, Matisole. Matisole is a good girl at home, where she takes care of her younger brothers and sisters. Her parents and others view her as a good girl. When she leaves her house, she becomes a *chola*, which is to say she is identified with a gang. Because she is good at math, she is in an academic outreach program. So she is a good girl in that context. This gives you a glimpse of the flavor of how, in navigating from world to world, children can flip off and on these switches of good and bad, daughter and gangster identities. As researchers, we want to understand this, but we also want to help practitioners and policymakers get up close and personal with these realities of children's lives. In order to understand, we have begun to think in a new way, and we call this an intergenerational pathway approach.

We start with preschool children. As they start out, they are also moving across generations by seeing and participating in activities with older members of this pathway. For example, Matisole's younger sister, who is a preschool-age child, comes with her to her academic outreach program, and with her *chola* friends. As a Head Start child, her younger sister is observing, and in some sense, participating vicariously in these activities. Children in middle childhood are often viewed as more responsible and often in charge of caretaking with the smaller children. They also are protected many times by older youth, including gang-affiliated youth. We see a lot of older youth who take on roles as older siblings in the family and are often done in junior high or high school. Some of these children are out of school already. They have left the academic pipeline, but they may still be supporting their younger siblings who are still in school environments.

We see a key element in this pipeline, or pathway, as the young adults who help link pathways by helping children who are younger and also youths staying on the good path, or the *buen camino*. Many of the young adults with whom we see involvement have gone away to school and

Methods for Assessing Low-Income Minority Families

returned to their communities to work in community-based organizations, including Head Start. They often are tolerant of children who have left the good path and want to explore coming back onto that pathway. Mature adults include parents and teachers, but also *comadres* and *compadres* and other kin who may serve a guiding role. We are interested now in the individuals who may become executives, who hold positions of authority: school principals, program directors, program evaluators, individuals who can play a key role in linking or in unlinking these pathways.

Finally, we are coming to see an important role for what we call the ancestors. These are individuals who may no longer be living or who are elderly members of the community and may be grandparents. Caesar Chavez is an honored member of the ancestor generation in the central California area. Dr. Martin Luther King would be an example in many communities. However, there are also fallen comrades. In gang life, there are individuals who are revered as ancestors from the past.

The key idea of the intergenerational pathways framework is that it is helping us open up our thinking about competence and identity. Rather than categorizing the individual who is bad or good on the pathway, or in a particular ethnic group or category, this appears to be the terrain of development that will help us understand the resources and assets that children, families, and community practitioners may draw upon.

In our central California site, we have sought to work with this model in a project that focuses on the academic pipeline. We are working in partnership with two particular community organizations that have a lot of linkages with Head Start. One is a program called Barrio Cénidos, a national organization designed to combat gang warfare. This organization was founded by former gang members while in prison who are determined to change the way their younger brothers and sisters experience their childhood and youth. They offer academic support, personal support, and job training in their programs, and they involve preschool and elementary school children. The second program is more academically focused. It is one of the I Have a Dream programs, which extends college scholarships to children during elementary school. This permits children to set their goals for the *buen camino* of staying in school when it would most make the difference, when they are still in elementary school.

We start asking the children, "What are your worlds like?" We help them draw maps of their worlds. We give them throwaway cameras to take pictures of their multiple worlds. That is where we start to see the ways in which these identities flip on and off, the chola identity in one situation, the good daughter identity in another. We begin our partnership also by helping each of these two organizations set up databases in which they keep track of things like attendance in different programs and participation in different aspects of their programs. We help them begin to make presentations to their funders about the kinds of things they might want to be saying or indications of success and competence at the program level. As I have mentioned, we have been developing new methods for mapping the pathways through these multiple worlds that are appropriate for younger children that involve drawing and even walking us around their worlds with cameras. We have also helped develop curricula that are available for people who need things to do in those after-school programs. The key point is that this work rests on coordinating the goals, needs, and perspectives of the different stakeholders in this process in a way that enhances trust. It supports the sense of collaboration and includes our volunteering in the agencies.

It is heartening to see the new alliances and intercommonality that starts to be developed. There is a sociologist named John Brown Childs, who is now writing about the ways in which we need both a sense of ethnic and group identity, as well as intergroup alliances and intergroup partnerships. These can begin on the ground just the way they did in the summer of 1965 when a lot

Methods for Assessing Low-Income Minority Families

of us began with Head Start as community-based action programs. We are seeing new kinds of partnerships. We are all part of a much more interethnic process that leaves some of those categories behind for awhile. These are very much on the table, but they are not always the things that divide us. They are often the things that motivate us to bring ourselves together on behalf of the children.

Juanita Santana: I am going to give my perspective on the practitioner's point of view. I would like to address what I call the essential guiding principles that funders and universities across the nation need to keep in mind when designing and funding research projects that will apply to ethnic and racial minority populations.

It is critical that families be seen as a part of a greater system. I place quotation marks around the term "dysfunctional families." Dysfunctional families do not happen in a vacuum. They are the product of dysfunctional societal systems. We must avoid the temptation to blame families for their inability to cope. In the present political environment, families are being blamed for being poor, for being different, and for not being able to cope. These families deal with challenges that are greater in this time than ever before, and they are facing them on a daily basis in their communities. The notion that programs such as Head Start need to develop better models for intervention is only a part of this illusion. It is not the whole answer. We must recognize that families function as part of communities, and the communities are part of greater social, economic, and political systems. These systems determine the environment that will shape the future of families by either giving them the opportunities for success or creating an environment where families will fail.

It is important that we carefully avoid the assumption that families have the skill to cope with environmental detente, and if they do not, then we must somehow teach them or fix them so they will be able to cope better. It is dangerous because we are taking away the responsibility from the greater society.

I want to talk about a national social strategy that needs to be developed. The only way we are going to be able to do that is by utilizing the research that we are talking about with the approaches that we are talking about with the practitioners, and seeing where are we going. The research also must focus its work on the forces that shape the environment in which families live. This includes determining how prejudice, racism, and discrimination, both on an individual and an institutional basis, impact the development of children and families. This is an area that is ugly and that we continually avoid because it is a difficult issue. However, we must put it on the table and start a national debate about how children are being impacted by this. We know very young children are already aware of the differences and are selective in their behavior towards one another. The research community needs to ask the hard questions. Communities should have access to findings from research. They should be able to incorporate the information into their family support systems and intervention strategies. Policymakers need to use this information to establish decision-making processes that consider social and economic policies. Only with this broad approach can we hope to develop a social strategy that is based on nurturing families and children.

Another key element is that all families must be treated with respect. Research must be designed and conducted in an approach that clearly recognizes and validates the family's value systems as ones that are intrinsically good. I have in my years of practice yet to find a parent who is wishing that their children grow up to be homeless or to be involved in criminal activity. Depending on the race and the ethnicity or cultural background, each group has different

Methods for Assessing Low-Income Minority Families

approaches or styles of teaching, parenting, and nurturing children. We should not be surprised that we do things in different ways. However, we must not use these differences as a reason to treat people of different backgrounds as exotic or deficient. Even if sometimes we do not understand, we must avoid the assumption that because something does not feed the accepted pattern, we need to change them so they can be more like us. Respect includes the empowerment of parents, of families, by involving them in the development of measurement tools. These tools recognize their strengths as families and recognize the resilience that the families possess, the perseverance that they have to continue to face the challenges.

The third aspect is that there has to be a balance between the quantitative and qualitative data. Joan McKnight said that policymakers learn from data and communities learn from its stories. The challenge for researchers is to develop measurement tools that use the stories that families have to tell, and then transform them into the hard data that policymakers need to make decisions. Another consideration is that researchers must be culturally competent.

Those are the things that struck me as critical to be able to work together and utilize the research that is taking place now more than ever with the practitioners. I would like to close by quoting one of the greatest thinkers of this century, Albert Einstein, who said, "We cannot begin to solve the significant problems we have with the same level of thinking with which we have created them."

Audience Questions and Comments

Comment: In addition to dealing with this issue of racialization, we also need to integrate that same kind of critical thinking about class and gender. I was particularly thinking of Diane's work. I also found interesting this distinction between an individualistic and a collectivist approach. I grew up in a White, working-class family, and when people started talking about this, we did not fit in the White group. Then when you add in gender, that is another issue. Many women come to a self-definition by defining themselves separate from others. So there is the argument that we need to reconceptualize.

The other thing that we need to take seriously is the point that was made about studying these issues with White families. I also like what you said at the end about learning some people's stories. I do ethnographic research, and that is what it is about—listening to people's stories. I work in Pittsburgh, PA, with an Early Head Start program that was a CCDP and is now part of the MacArthur follow-up study. About two thirds of the families in the program are African American; about one third are White. One thing I found disturbing in terms of the White families is their difficulty in telling their stories of who they are. The African Americans can articulate that much more clearly. It includes both an experience of racism and racial exclusion, but also certain kinds of strengths and identities with family and community.

Comment: What you shared is important, and I think about this all the time. I do not know how we will study it. We hope to study how children develop a sense of privilege, along with understanding how children of color develop a sense of their status in society. If, when you try to talk to individuals who identify themselves as White, and they do not have an understanding of what it means to be White, or they cannot verbalize it, how then is it that we have a racist society? Something must be there that they understand but cannot, or will not, share in a setting in

Methods for Assessing Low-Income Minority Families

which you talk with them. There must be something that gets into children's heads. Somehow we need to understand what it is.

Comment: We have been doing qualitative analysis with African-American, White, and Native American families. One of the sets of questions we asked them was about their values and where they come from. African Americans and Native Americans have a much clearer system of saying who I am, where I fit, where I come from than do our White, low-income families.

There are two issues here about being White that do not get addressed. One is that we have not talked to the men. Being White for a woman and being White for a man are likely to be different identity experiences. We have got to be careful about crossing the gender boundaries and making assumptions about the culture based on the female informants. The second part is that there is a power versus powerlessness. It is not as much about social class as it is about powerlessness. We see that especially in our White families, because some of the ones who have moved into middle class seem to be able to better articulate who they are when they have made that transition.

Another thing that I hear all the time from White students is that race and ethnicity are not issues in their lives. They have not thought about these things. What some students have been able to say relating to the class power issue is that their grandfather came here 60 years ago poor. With recent European immigrants, it is the same thing—they describe themselves as being American, not as Hungarian American, or Romanian. This is the part of your psychological experience that is a disconnect or that is a source of dissonance. Part of the dissonance is the implicit sort of macrosystemic value that anything that is not American is seen as not being as good. As people acquire more money or perceive that they have more money, it is easier to talk about those people, because you have moved away from that. In a lot of ways, as researchers, we have not helped to raise that issue, with the exception of some of the people recently who have been talking about White racial identity development. Even that model is filled with problems because it does not deal with the issue of a developmental trend.

Comment: Research on low income does not automatically mean low income as American people of color. It does involve European-American families and children. There is little research for African-American, working-class families around. It is usually the very poor, with a little on middle class, but nothing on working class. I keep waiting to hear about the family I grew up in with Mama and Daddy both working. We need to distinguish, because there is often the deception that poor people and people of color automatically go together. Urban automatically goes with it. Rural poverty is just as strong. We need to keep looking at that and separating those issues out.

Diane Scott-Jones: I could not agree with you more. We are starting to do focus groups with families, and we have gone in Philadelphia to African-American independent schools and to African-American churches to try to get the kinds of families you were talking about. From the time I was a graduate student, I knew it was not my family that was being talked about in the literature. I have often wondered where the families came from.

Methods for Assessing Low-Income Minority Families

■ Assessing Families and Neighborhood Conditions in Hispanic Communities

Chair: Sheila Smith

Discussant: Carmen P. Cortez

Presenters: Todd Walker, Virginia Rauh, Jeanne Brooks-Gunn, Gilberto Cardenas

The use of new methods for assessing family characteristics and neighborhood conditions within Hispanic communities was described. Relationships between neighborhood conditions and family well-being were examined. The potential value of these methods for practice, program design, and the evaluation of comprehensive programs and community change initiatives were discussed.

Assessing the Impact of Comprehensive Programs for Hispanic Children

Todd Walker, Gilberto Cardenas

Paper summary not available

Conceptualizing and Measuring Family and Neighborhood Social and Economic Resources in Hispanic-American Communities

Jeanne Brooks-Gunn, Virginia Rauh

The purpose of this project was to better understand the processes by which urban poverty transmits its adverse effects to the developing child, especially among immigrant populations for whom traditional instruments and methods of assessment may not be appropriate. The project had five specific aims: 1) to identify neighborhoods that vary in terms of socioeconomic conditions and ethnic integration; 2) to examine the psychometric properties of commonly used measures when applied to Hispanic-American families; 3) to develop new, culturally sensitive measures; 4) to integrate new and traditional neighborhood-based measures in an interview protocol designed specifically for use with Hispanic families in selected urban neighborhoods; and 5) to train Hispanic-American graduate students.

Recent work suggests that the HOME inventory may be less useful among Hispanic and other minority families, as compared to White, European-American families. Using samples from the Infant Health and Development Program and a longitudinal study of children born to inner-city, minority families residing in northern Manhattan, we confirmed the weaker predictive power of the HOME inventory among minority families. To address these limitations of the HOME, we refined and restructured observer-rated questions, modified the coding of these items, and developed new items to better assess the important childrearing domains in Hispanic families. We also added several domains with particular relevance to the childbearing practices of immigrant families, such as acculturation and social isolation. Our new Family Advocacy Measure contains three sections in which parental advocacy may occur: the education system, the entitlement system, and children's special needs (academic, medical, social/psychological). Items tap whether parents participate in their children's receipt of services and whether they seek to improve the services their children receive. Although it is too early to assess the predictive validity of the newly developed items for subsequent child development, results suggest that these items have adequate variability and are moderately associated with the traditional subscales of Home Learning and Acceptance/Punitiveness.

We also explored patterns of association between the HOME and community conditions, as defined by "Concentrated Poverty Area" (those neighborhoods in which more than 40% of the residents fell below the poverty line). We were interested in whether residence in a poor neighborhood was associated with adverse mother-child interactional patterns, regardless of individual

demographic attributes. We classified the sample into concentrated and nonconcentrated poverty areas (although the nonconcentrated poverty areas were not affluent in the present sample). Analysis of covariance and multiple regression techniques were used to assess the contribution of community-level variables to parenting practices, while adjusting for the effects of individual family characteristics. Results showed that families who reside in high-concentration poverty areas had significantly lower scores than families who reside in nonconcentrated poverty areas on the parent-child interactive subscales and physical stimulation subscales of the HOME, after controlling for the individual effects of maternal education and income.

Overall, we were encouraged by the results of this pilot work, which suggests that broad aspects of the quality of economic conditions in the community are quite powerful determinants of home conditions and parenting practices, in particular, and these effects hold up among minority, inner-city families.

■ Strengthening the Links between Research and Practice: Lessons Learned in Conducting Research on Children, Families, and Communities with Multiple Challenges

Chair/Discussant: Judith J. Carta

Presenters: Jean Ann Summers, Jeanie Schiefelbusch, Martha Staker

As children, families, and communities face greater challenges in today's society, researchers and practitioners are working together to create comprehensive interventions based on research outcomes. This symposium brought together researchers and practitioners who have used qualitative methodological approaches for translating research to improve intervention practices addressing these families' needs. The first panelist, Jean Ann Summers, described the use of focus groups to help service coordinators identify the most effective practices used in carrying out responsibilities to families. This technique, called "Critical Thinking," was used to generate categories of responses identified as most promising by two different agencies engaging in two separate series of focus groups. Among the successful steps identified were 1) the importance of timing in coordinated services so that they could be utilized most effectively by families at critical junctures, 2) the importance of moving families out of "crisis mode" and into one in which they perceived their own strength and control over their environment, and 3) the need to overcome families' distrust by establishing common links and displaying friendship and acceptance of these families.

The second panelist, Jeanie Schiefelbusch, described the use of focus groups to direct the development of home, school, and child care interventions for young children prenatally exposed to drugs. Separate focus groups for parents, early interventionists, health care professionals, and child care providers identified developmental areas of greatest concern (i.e., language), intervention strategies considered most effective, and barriers to providing quality interventions to children and families.

The third panelist, Martha Staker, described the use of organizational ethnographic methodology to enhance a Comprehensive Child Development Program, a two-generation program offering comprehensive and integrated services to children from low-income families. Through frequent interactions with program staff, families, and members of the community, the ethnographers helped program staff identify critical program features relevant to program quality, relationship and communication dynamics, and interactions with families in community context. In particular, the ethnographic research component assisted the program in clarifying the needs of the families and communities it served by describing the historical evolution of the project and identifying staff development needs.

Overall, the symposium provided clear examples of the ways in which qualitative research can assist practitioners in critically reflecting on their process of program implementation. Alternatively, it also exemplified the manner in which practitioners can guide and make the intervention development of researchers more relevant to their needs. Discussion followed that underscored the need for meshing both a quantitative and a qualitative approach to this researcher and practitioner partnership, so that critical reflections on process by practitioners will be linked to program outcomes.

Critical Thinking: Using Focus Groups and Qualitative Data Analysis Methods to Investigate Model Intensive Service Coordination Programs Serving Families with Multiple Challenges *Jean Ann Summers, Alice Kitchen, Oneta Templeton-McMan*

Intensive service coordination is a service model providing whole family support in an intensive, flexible, and coordinated program intended to meet whole family needs. This model is increasingly advocated to meet the complex needs of families with multiple challenges. Yet, there is little understanding of the dynamics of intensive service coordination, or what specific practices are most effective in meeting the needs of this population. This study applied the methods of qualitative research, specifically focus groups and ethnographic data analysis techniques, to identify characteristics of families with multiple challenges and strategies that worked in addressing those characteristics. The study involved two staff of five members each, who provided intensive service coordination in 1) a family preservation program and 2) a program serving families of infants who had been prenatally exposed to drugs. The staff were asked to provide examples of "successes" and "failures" in their practice. After each meeting, notes were transcribed and sorted, putting word and concept associations into sets of categories. These categories were, in turn, submitted to the staff at subsequent meetings, and the resultant discussion was transcribed and "folded in" to the databank. A total of 11 yielded 27 categories of family characteristics and 48 categories of program and staff strategies.

First, families had multiple and long-term challenges encompassing both internal challenges (e.g., dual diagnoses, family violence, substance abuse) and external challenges (e.g., chronic and long-term poverty). Strategies that appeared effective in addressing these multiple challenges included careful timing and coordination of multiple agency involvement to converge on these multiple needs. Second, families were chronically in a state of crisis, either due to limited resources or other psychosocial factors (e.g., perceiving crisis as "normal"). Strategies used included providing concrete resources, being flexible about goals and interventions, and teaching effective problem-solving. Third, families were alienated and distrustful due to long histories of betrayal by both their extended family and the service system. Effective strategies included consistency and honesty, accompanied by persistence in passing "tests" to earn the family's trust. Fourth, families exhibited learned helplessness and extremely low self-esteem. Service coordinators addressed these needs by demonstrating consistent regard for the families, serving as role models, and shaping problem-solving and initiative-taking on a step-by-step basis. Most important, as a strategy to meet all these characteristics was a commitment by the staff to a family-centered, individualized approach that met the family "where they were" and encouraged initiative, yet allowed the family to feel the consequences of their choices. Program management and policy implications were also discussed, including the need to negotiate coordinated community services and to develop a strong support system for both training and flexible supervision of the staff.

Community Focus Groups *Jeanie Schiefelbusch, Phoebe Rinke*

Results were presented from a series of focus groups conducted among the following groups: biological, adoptive, and foster parents; early intervention/early childhood special educators; child care providers; and health care providers, based on their experience in parenting or working with a child (or children) with prenatal exposure to alcohol and/or other drugs. The objectives of the focus groups were 1) to identify behaviors and characteristics exhibited by infants and young children with a history of prenatal exposure as observed by participants and to determine from their experience if these children differed from children from similar backgrounds

Methods for Assessing Low-Income Minority Families

without a history of prenatal substance exposure; 2) to determine which behaviors and characteristics caused the greatest concern and how these behaviors can best be addressed; 3) to identify the implications of these characteristics for child/caregiver interactions and for the child's future developmental outcomes; 4) to determine the intervention strategies that caregivers and professionals identify as being most effective for the behaviors/characteristics described; 5) to determine what barriers/challenges exist to providing interventions and services to children and their families; 6) to determine what additional information caregivers and professionals would like others to know about children with prenatal substance exposure.

Areas of developmental concern identified by each of the nine focus groups in the four provider categories (parent, child care, educators, and medical) were language delays, irritability/excessive crying, aggression/behavior problems, sleep difficulties, feeding problems, difficulty in consoling, and tremors. Other developmental concerns frequently identified included short attention span, social interaction difficulties, hyperactivity, problem play behaviors, overreaction to environmental stimuli, and abnormal muscle tone. Each group emphasized that the behaviors and characteristics they reported, however, were not evident in all children whose mothers had used substances while pregnant, and that when characteristics were present, they were manifested in varying degrees of intensity. Additionally, these behaviors were not necessarily indicative of children with prenatal exposure, but were also present in children whose mothers did not use substances when pregnant.

Areas of priority concern identified by each of the four provider categories helped to identify some of the areas for which future intervention efforts should be targeted. Successful intervention strategies for developmental concerns most often identified by focus group participants were highlighted, which indicated strategies that caregivers and practitioners found to be most helpful. In addition, recommendations regarding helpful strategies/services for parents identified by each of the provider categories included topics such as the need for role models, parent education, and case management. Helpful strategies for professionals included the need for ongoing staff/professional training, quality programs and services for children and their families, and positive feedback from families.

Where should our efforts really be concentrated? Focus-group participants overwhelming expressed the need to identify prevention issues (early prenatal care, parenting programs, teen pregnancy, etc.); service delivery issues (parent education, home visiting, community-based services, mentoring programs, case management, staff training, etc.); and policy issues (child care, coordinated interventions and services, etc.) Input from these focus groups is currently being used to direct research on the development and adaptation of intervention strategies that parents, caregivers, and other practitioners consider most important and most useful.

Organizational Ethnography As a Means of Program Enhancement *Ed Canda, Martha D. Staker*

Project EAGLE, initially a Comprehensive Child Development Program and now an Early Head Start research program, has worked in partnership with Organizational Ethnographers for seven years to study the historical development, ongoing operations, and factors facilitating and inhibiting program objectives. Ethnographers interacted with program staff, families, and the community on a frequent basis and recorded their observations and interviews. Specific core areas of service that were investigated included child care, health care, transportation, adult education, parenting, education, housing, service integration, mental health issues, program develop-

Methods for Assessing Low-Income Minority Families

ment, ethnic diversity, family goal attainment, family satisfaction, case management, parent involvement, and male involvement.

Seventeen reports were written during this time. Ongoing debriefing sessions with the staff resulted in relevant information and timely programmatic changes. Four major criteria were used to assure methodological rigor: credibility, confirmability, dependability, and transferability.

The organizational ethnography impacted the program in four ways:

1. *Ongoing Operations*: Reports and visual diagrams described the multiple and complex needs of families, as well as the multiple systems that families had to interface with in order to have their basic needs met. This confirmed the need for a comprehensive, integrated service delivery model. Staff expanded their mental models and preconceived notions of male involvement, self-sufficiency, and empowerment, based on observations and interpretations within the reports. Family satisfaction surveys buoyed the staff and reinforced the services that families identified as most important. Needs such as adequate housing and transportation were described as family needs and community needs. Reasons why families left the program were tracked and later shared with all staff. The relationship between staff and families was described as a major factor in motivating families. Families confided in the ethnographers that they wanted more ownership of the program in order to gain incentives to recognize their efforts.
2. *Conceptual Framework*: Reports helped the program staff understand that change was occurring within the organization because it was an evolving, learning organization. This interpretation was helpful to staff who initially believed that change was occurring for the sake of change or from lack of leadership and management skills.
3. *Historical Documentation*: Ethnographers documented the historical development and defined the developmental stages of the program. This was critical as the community strained to understand the complex start-up issues. Reports tracked the program's progress and periodically compared and contrasted it to the program's beginnings. This contributed to the replication of the model and the necessary knowledge to offer training and technical assistance to similar programs.
4. *Staff Development*: The reports helped the administrative staff identify the characteristics of individuals that were most likely to succeed in working in a comprehensive, multigenerational program. Training needs were identified, and levels of staff satisfaction related to program services were recorded.

Organizational ethnography offers opportunities to systematically reflect on the program. It has a synergistic relationship when done in concert with process and impact evaluation. In order for this type of research to be most effective, it must be done within an environment of trust and cooperation. It is time consuming, but not costly.

■ Methods for Head Start Research: New Developments and Recurring Issues

Chair: W. Steven Barnett

Presenters: Virginia Rauh, Gregory Camilli, Sue Marcus, Robin Jarret

Virginia Rauh: Community-based programs (like Head Start) are "embedded" in communities. This means that they hire staff from the community, enroll children from the community, work with parents from the community, and, in most cases, depend upon the resources of the community. Some programs may look reasonably effective while others will have no demonstrable effects, despite the fact that the formal content of the services are generally similar across sites. Furthermore, in large-scale evaluations that pool many programs, the "average" benefit may appear to be quite small, when, in fact, the program works very well for some children or in some areas.

Most likely, there will be variation in program effectiveness, and a portion of this variation may reflect community-level conditions; that is, some programs have a harder job because of the specific population served (a greater proportion of the population is at risk), or because of a lack of resources in the region. Early benefits for most children may appear to "wash out" later on for some children. Why? Multilevel theory suggests that influences on a child's development are ongoing and that the multiple contexts in which he or she resides are important. This ecological perspective has a long tradition in the field of child development. Probably the most fundamental theory derives from Brönfenbrenner, although Belsky, Cicchetti, and others have built on this and have specifically thought about contextual influences on parenting and child maltreatment. This thread of work contributes the strongest evidence that *individuals* are affected by different levels of the environment and suggests some developmental mechanisms (although most mechanisms have not been empirically tested). Garbarino was one of the first developmentalists to think about how to define community quality.

The most useful analogy to explain multilevel analyses (especially for the evaluation of Head Start effects) comes from the educational literature, which is where the method was first applied. Children are grouped in different classrooms, located (or nested) in different schools and school districts. Some classrooms have excellent teachers and the children have good outcomes (i.e., their reading scores improve, few children need special education, etc.). However, the ability of the teachers to be effective is somewhat dependent on school or school district quality (i.e., the student-teacher ratio, amount of money for supplies, level of discipline in the school, adequacy of the physical environment, presence of a school lunch program, etc.). These "contextual" factors may be just as important determinants of an individual child's outcome as his I.Q. or the skill of the teacher.

Each program is a "classroom" in which families participate and receive intervention. All of the programs are nested in communities, and these communities can be classified or ranked according to quality or risk. Families enter the programs with different levels of individual risk, but the overall effectiveness of each intervention program in preventing child abuse or fostering positive family outcomes may depend upon some conditions in the community, as well as individual risk status. For example, some communities will have an accessible health care system, adequate child care services, and a strong network of informal social supports or social cohesion. Other communities will have significant barriers to health care, poor transportation systems, few parks or other safe places for families to gather, and so forth.

Factors influencing the families' outcome will be both on the individual and community level, so that both kinds of factors could be included in any evaluation of program effects. So far, this sounds logical, but a problem arises when the analysis includes *both* kinds of factors. This is because the factors are not independent; that is, families are not randomly assigned to communities (just as children are not randomly assigned to schools). Their individual characteristics contribute to where they live, so that families with higher incomes may choose a higher quality community, or immigrant families may choose a community where people speak their native language. Similarly, families may be excluded from certain neighborhoods on the basis of racial discrimination, and so forth. It is only recently that statistical methods can deal with this kind of non-independence (e.g., Hierarchical Linear Modeling).

In the evaluation of intervention program effects, it is a real advantage to be able to assess the contribution of both individual and community-level factors to program success. For example, it may be that the intervention succeeds in providing social support, linking a family to a medical home or preparing a child for school, but community conditions may be so unfavorable (i.e., high unemployment rates, high crime rates) that there is no reduction in the likelihood of child abuse. An individual-level evaluation might show no program benefits at one site, whereas a multilevel evaluation might be able to show the level of community risk at which the benefits of intervention are washed out. This type of information would be especially useful in the targeting of scarce resources, or determining which level of intervention services are needed. Such a multilevel approach might also show who is most likely to benefit from services in a high-risk community. For example, perhaps teenage mothers are helped by a home visiting program, despite adverse community conditions.

Multilevel approaches to the study of the effectiveness of intervention program are being widely advocated, but very few program evaluations have actually incorporated the method. This is partly because the design requires multiple sites with a uniform database.

Ecological Analysis. There are several ways that a program may begin to think about a multilevel approach. These include an ecological analysis: a detailed assessment of community conditions; the merging of individual and aggregate-level data; and the use of multilevel modeling analysis. This means collecting information on community-level sociodemographic indicators and indicators of child well-being. Ecological models would be developed for each county to see if the predictors of child abuse are consistent across a state, for example (particularly, to see how the rural and the urban models compare). This is not much different from what Garbarino and Kostelny did in Chicago in 1992, except that their model was a simple linear model. The literature now suggests that social problems pile up very fast at the low end of the sociodemographic continuum (the epidemic theory); that is, at some point, social conditions become so unfavorable that the community "tips" and rates of illness, child maltreatment, delinquency, and so forth skyrocket.

Detailed Assessment of Community Conditions. You might want to go beyond the usual secondary data sources and try to characterize communities (at least those sites where we have programs) more completely. Several methods have been developed, such as drive-by techniques, where certain kinds of services (ATMs, grocery stores, libraries, etc.) are counted. Other methods consider other measures of "social capital," such as informal networks, social clubs, local newspapers, and so forth. Some of these methods use key informants and focus groups. Finally, it might be important to think of ways of calculating actual dollars flowing into a community or the converse: the reduction of public services over time. Some recent work suggests that the reduc-

Methods for Assessing Low-Income Minority Families

tion of public services foreshadows population loss and an increase in crime and illness. This is much more labor intensive, and somewhat descriptive, but yields very rich data.

Merging of Individual- and Aggregate-Level Data: This requires a clean individual-level data set, the development of some good hypotheses, and the appropriate software. All individual data must be geocoded, so that individual addresses are linked to larger areas of analysis (e.g., neighborhood, health area, school district, census tract, etc.).

Multilevel Modeling Analysis: The quality of the analysis will depend upon the adequacy of the individual-level model (from the literature and local data sets). The next step is to classify communities on the basis of their aggregate-level indicators (using sociodemographic data and some measure of existing services and resources), perhaps into highly desirable and less desirable communities. For example, one strategy would be to use several indicators as a summary of community quality. Some researchers have used factor analysis. The key thing is to select indicators that are consistent with the ecological models that apply in the region, perhaps looking at urban and rural sites separately, or developing separate models for different populations. Preliminary questions of interest concern the relationship between community-level conditions and individual risk (pre-intervention risk) in different types of communities. Next, try to construct a two-level model to explore whether or not the addition of community variables changes the relationship between individual risk factors and individual outcomes (already explored within the individual-level data set). Questions concern how community conditions affect the success of Head Start with respect to preparation for school, longer term academic performance, social outcomes, and so forth for specific populations of children.

Gregory Camilli: Quasi-experimental designs have been severely criticized for a number of years. Donald Campbell pointed out the threats to the internal validity of these experiments at least 20 or 30 years ago. In 1975, Campbell wrote an article listing six ways that threats to internal validity can make weakly beneficial programs look harmful. Among these threats are under-adjustment. Most Head Start and non-Head Start children that are compared in studies are not equivalent for a host of reasons. Campbell warned about poorly matched studies, regression artifacts, unreliability, and covariance. He also listed differential growth rates and increases of reliability with age, which is still poorly recognized among many people. He advised about lower reliability of the disadvantaged group, test floor and ceiling effects, and aggregation bias. It was clear that Donald Campbell was aware of Carl Yorskoff's work. I dug out some of my old notes and I found a letter dated July 12th, 1976, from Donald Campbell to a research committee. "Dear friends, there are so many things that can affect test scores other than Title I and other resources. God will forgive us if we divert some of this massive funding into a few small, well controlled randomized studies of promising programs that experienced practitioners still have great faith in. Lacking that, we must attempt to look at the evidence, to seek analyses that rule out all of those plausible rival hypotheses we have thought of." That is still a good message today. I do not think that the terms of experimentation have changed. There is always going to be a tradeoff between smaller, well-controlled studies and more massive types of survey studies.

Steve and I recently examined a study by Currie and Thomas on the effects of Head Start. This study used the National Longitudinal Survey (NLS) data set, which at face value has a sample size of 8,500. Face value in that study is very misleading, but on the basis of that evidence, Currie and Thomas concluded that Head Start programs serving African-American children were not cost-effective. I have two responses to that. First, is it possible to make that type of conclusion out of any one study, even given that you had a randomized, well controlled experiment?

Second, we need to take a look at the evidence. Perhaps there are some weaknesses of this quasi-experimental design in reaching this conclusion. Numbers in the thousands become quite small when you look at Currie and Thomas's actual analytic sample. For example, out of the original 8,500 for the Peabody Picture Vocabulary Test (PPVT) analysis, there were only 214 White children, 189 Latinos, and 359 African-American children. For other outcome variables like grade retention, there were 13 White children, 33 Latinos, and 90 African-American children. Currie and Thomas used a fixed-effects model, which looked at differences between Head Start and non-Head Start children. That means that you can only pull out families with at least one child in and one child not in Head Start. This is related to Campbell's first point about under-adjustment. Adjustment has to take place because there is a selection difference between experimental and control groups. Perhaps more important in the evaluation is the statistical question about how you choose outcomes. How do you match outcomes to the goals of the program? Can you do this sort of thing in survey studies or large-scale studies? If we do a large-scale study, it is hard to manage hundreds of applicant variables. The pressure is to focus on a few.

Currie and Thomas used the PPVT as their main source of cognitive information, so it is worth looking at how good the PPVT is for this purpose. Histograms showing percentile scores indicate a huge frequency around zero. These are percentile scores, not raw scores, so a zero percentile score means you are scoring very low relative to the norms. For two to three percent of the White children, a baseline could not be reached. In other words, children could not get the easiest questions correct, which calls into question the quality of the outcome measures. The distribution for the African-American children indicated that there was a problem with floor and ceiling effects in this test. In fact, this was such a problem that I started thinking that something was wrong with the PPVT. The first eight questions on this test are things like "What is a bus? What is a hand?" It is very hard for me to believe that this distribution could happen with good testing procedures. For about 10 % of the African Americans, a baseline could not be reached, which also led me to believe that there were some problems with the testing process. In fact, there was a floor effect up to age 13 or 14 for the African-American children.

What can go wrong with large-scale studies? You can choose outcome variables that are not matched well with the population you are studying. The four year olds are apparently having trouble with questions such as "Point at the bus." I cannot come up with a valid explanation for this. I could see a number of problems with an item that asks children to identify tractors. Tractors no longer look like the PPVT picture. Some children are going to be unfamiliar with other types of tractors, and some of it is going to depend on the child's neighborhood or community and the quality of his/her school.

The regression results from the Currie and Thomas study indicated that the Latino Head Start children gained nine percentile points, the White children five, and African Americans zero. The regression coefficients on age indicate that scores that were already standardized with respect to age tend to get higher with age for the White and African-American children. If these were raw scores, you would understand that as children get older they tend to get more questions right. However, the scores are already standardized with respect to age. One explanation for why older children are getting higher scores is that there is an attrition effect. The children with lower scores are no longer being tested. Thus, another problem with large-scale studies is missing information.

You can do alternative types of analyses. In one type of analysis, I created groups based on selection scores. I used a propensity model to create equivalent groups based on preexisting variables. It is a different way of trying to create equivalence. For three out of the four groups in this type of analysis, it looked like there was a positive difference in the PPVT. If you add these up

Methods for Assessing Low-Income Minority Families

and come up with an aggregate, the African-American children appear to be making about a five percentile point gain, whereas with a different analysis, it looked like they had a very slight loss. Different methods of analysis can lead to very different results. What do you need to make these types of quasi-experimental studies credible? At the very least, you need to show some sort of convergence between different methods of analysis.

Sue Marcus: I would like to talk to you about some alternative statistical models that I used in analyzing the long-term benefits of Head Start, and some of the methodological problems evident when trying to evaluate programs like Head Start, in which there is no randomized sampling at the beginning of the program. We needed some special methods, because before the analysis of the data, we thought that we would have the problem of noncomparable groups, because there was no natural control group since there was no randomization in the beginning. In this case, the control group was composed of adults from similar neighborhoods and schools. Even though this control group was set up very carefully, we assumed that the most impoverished children were recruited for the Head Start program; consequently, the remaining people in these neighborhoods were somewhat different than those in Head Start. I want to mention Campbell and Stanley's work in 1975. They were aware more than 20 years ago that any evaluation of Head Start programs probably will underestimate the effect. This problem of underestimation is very important at the policy level because it is hard to explain that what you see is not what you really have. The best analogy I can think of is the census, where we know that if you try to count people, it still will not be the best estimate of how many people really are in this country, because there are many homeless people and others who just do not want to be counted.

As we suspected when we compared the groups before the children entered Head Start, there were many important differences. I will talk to you about the evaluation in two sites: one in Florida and one in Colorado. The Florida site was predominantly African American; the Colorado site was predominantly Latino. In Florida, there were differences between those in Head Start and those in the comparison group on the number of fathers who were high school dropouts and parents who had been on welfare. In Colorado, there were striking differences in the racial composition of the Head Start versus no-Head Start participants, as well as the parents' education and welfare use. In addition, there could be a certain amount of measurement error in these variables because this measure involved recall from young adults about the state of their parents when they were in the Head Start program. However, even without that, the groups were very different in the beginning.

A good tool for adjusting the unbalanced groups is the propensity score. This was emphasized by Rosenbaum and Rubin. Basically, the propensity score is useful because it gives one score that will tell the probability of being in the Head Start group. It turns out that this score is a good indication of baseline socioeconomic status. It is easy to calculate the propensity scores using logistic regression and any statistical software like SAS or SPSS. The propensity scores can be used to balance the groups, at least with respect to the observed measures. We do not know how it matches groups on unobserved variables, but if good baseline information is collected, the propensity score can be used to balance groups. One benefit of the propensity score is that if there is missing data, one can still calculate a propensity score with the existing covariance. Most software packages will eliminate subjects that have any missing covariance. The other benefit is that hundreds of covariants can be used, whereas a regular regression cannot have too many covariants, especially if you have a small sample size.

As an indication of how this works, everybody in both groups is given a propensity score and then ordered with the Head Start and the control together. Those in the Head Start programs tended to have higher propensity scores. The controls tended to have lower propensity scores—a measure of how unbalanced the groups were. If the groups were the same, each of the two groups would have roughly 20% in each quintile. To show what the propensity scores do, I looked at the Head Start program versus the control group on the one variable of no welfare. In quintile 1, which was the quintile where most of the Head Start sample fell, the majority were on welfare, and as you go down to Q5, few of them were on welfare. The propensity scores break all the subjects down into the most impoverished to the least impoverished. They give additional evidence that the two groups were unbalanced in the beginning. As an interesting note, one of the things that went into the propensity scores was number of children. It seemed that in Latino families, the more children they had, the more impoverished they were. Propensity scores can be put in a regression to adjust. They can also be used for matching. Through the propensity score, you can match someone in the Head Start group with someone not in Head Start who started with the same propensity score. The nice thing about using this optimal full matching is that it uses all of the subjects and comes out with a good match that is easily understood by people at the end.

For example, for three of the outcomes in the Colorado study—years of education, elementary school grade-point average, and high school grade-point average, before we unadjusted using propensity score matching—Head Start was significantly harmful. After adjustment, it still looked as if Head Start was not quite as good in terms of long-term benefits, but none of them were statistically significant. In Florida, the results were a little less extreme. There were significantly fewer years of education before we adjusted, and after adjusting there was no significant difference. In the elementary GPA, it started to look as if Head Start was beneficial. However, the results are not in favor of the long-term benefits of Head Start. Even after adjustment, things look not harmful with respect to Head Start, but not very positive. Clearly, the unadjusted effects are misleading. After adjustment, things look about the same, but perhaps there is an unobserved variable. For example, the parents' attitude about the importance of education might lead to hidden bias. What we must do is look at how sensitive the study is to hidden bias.

To give you an example of how to assess hidden bias, let us say we have a variable called "W," and $W = 2$ means that someone is twice as likely to be in the Head Start group if you have that unobserved characteristic. For example, if your parents do not encourage you about education, you might be twice as likely to be in the Head Start group. As a way to assess how a certain amount of hidden bias might change the inference, it could be that a small amount of hidden bias could mean that Head Start really is beneficial. Since we are uncertain about the hidden bias, we want to look at a range of possible inferences. In this kind of sensitivity analysis, you can ask: What if Head Start is beneficial? That was our original assumption. We then can look at possible probability values that would be associated with each amount of hidden bias. For example, this particular hypothesis, $W=4$, would mean that you have an unobserved variable that would be four times more likely in the Head Start group. The P-value would be less than .05, meaning that it was statistically likely that the hidden bias would change the inference.

I would like to finish with a sensitivity analysis of Head Start. The W's for Florida were smaller than those for Colorado. Our conclusion is that in Florida the results are sensitive to a small amount of hidden bias, meaning that Head Start could be significantly beneficial. Colorado, however, is insensitive to hidden bias. There would have to be a lot of hidden bias to show that Head Start was beneficial. In conclusion, the problem is determining what to do when the groups are unbalanced. In this particular situation, we feel that the baseline state of the subject tends to

Methods for Assessing Low-Income Minority Families

have a much bigger influence than Head Start. If we think the treatment or the Head Start effect might be underestimated, all we can do is talk about the uncertainty and how sensitive the results might be to hidden bias.

Robin Jarret: I am going to focus on how ethnographic research methods can be part of a larger research tool kit. In some respects, my talk is going to shift a bit to bring families back into the equation and to get a sense of how they view their lives and Head Start. My remarks derive from three sources: 1) from past research that I have done with Head Start families, largely mothers in Chicago (a multiyear study, largely interview, some group interview, and some participant observation); 2) from an ongoing Head Start study that I am doing now in two inner-city neighborhoods that is based on participant observation; and 3) from a meta analysis of existing qualitative and ethnographic studies.

I want to focus on three questions in my talk today. First, what is the rationale for using ethnographic research methods? I want to talk about the substantive findings from these studies. Second, what do they tell us, particularly about African-American families who use Head Start programs? I want to think about some of the implications of our research findings for Head Start programs and also a guide for future research. Third, what kinds of insights do they generate? As a research method, ethnographers rely on participant observation and various forms of interviewing to generate rich, detailed accounts of social life. When these accounts are well done, we have a vivid sense of people's daily lives.

Ethnographic research methods are typically indicated when little is known about an area or a group of people, or where a field has grown stagnant or the research is dated. There is a growing recognition by those of us interested in Head Start that the families are changing, that they are increasingly impoverished, and that they are living in communities that have a wide range of social and economic problems. Ethnographic research also is indicated when we are interested in social processes and dynamics, meanings, and the context in which social processes and meanings develop. These foci allow us to do several things. First, it means that we can view people's lives up close and personal. When we do this, we sometimes are able to discern informal patterns that may not show up in less intensive approaches. We can also access people's beliefs, values, and attitudes. This is important in understanding the motivations of people and in understanding why they do what they do. Further, ethnographic approaches highlight the dynamic aspects of people's lives. Researchers can discern recurrent patterns over time that we might otherwise miss if we are looking at families and communities at one point in time. Finally, ethnographic research allows us to explore the settings in which people live and carry out the business of daily life. As one setting, the local community influences behaviors, perceptions, and parenting strategies that families are bringing into Head Start programs.

I want to summarize a bit of what we know substantively from the ethnographic literature. The first is about the organization of domestic groups. Organizationally, many of these families depart from nuclear family patterns. Organizationally, many of these families are embedded in domestic networks that may extend across multiple households. In looking at the range of families in various studies, we find several kinds of identifiable living arrangements. There is a shared living arrangement, where women and children may be living with grandmothers or other female kin. There is a pattern that I call "the satellite pattern," where women and children may live alone or with male companions, but they are interactionally linked to some type of central household. There are female-headed families, but probably fewer are showing up statistically. These are the women who are truly isolated from other sources of support. There also are two-parent house-

holds. Observations over time indicate that women and their children may be moving back and forth between these various living arrangements. The organization is quite dynamic. At one point in time, they may look female-headed. At other points in time, they may be part of two-parent households. We also get a sense of some of the reasons for the residential moves. There may be personal and family crises, or economic changes. Sometimes the residential moves are for the better, and, sometimes, unfortunately, they are not.

An important aspect of domestic groups is their resource base. Some are heterogeneous, and by that I mean they have family members who are working class and middle class, as well as poor. Other domestic groups are more economically homogeneous, where most of the people are poor or in low-wage jobs. These network characteristics are important, because they determine access to social and economic resources that influence the well-being of the women and children.

The second thing we know from the ethnographic literature is about internal dynamics. Here we are able to see a range of household systems. There is one that I call a "routinized pattern." In these families, there seems to be a regular pattern for carrying out domestic tasks of child care and chores. These families are very much on task. These more routinized patterns are typically related to two factors. The household composition may be more stable than some of the other ones, and there may be a family member who is kind of a family coordinator, whose task is to coordinate all family functions. The second type of household system that we find has a much more flexible household routine. These families have greater variability in how tasks are performed. The dynamics of the flexible routine are related to three factors: greater changes in household personnel; larger family size; and multiple families living together.

In addition, when we look at the economic circumstances of women and men, life history and observational data indicate that poor women, contrary to some of the common stereotypes, have some employment experience. However, what we find is that the job characteristics, personal circumstances, and welfare characteristics come together to make it difficult for women to have a fairly coherent employment history. The kinds of jobs that these women are involved in are low paying. They are sometimes off the books. They have few benefits, and they may be located away from the communities in which they live. Child care is a major problem. Some of the child care arrangements are quite tenuous, and they prove to be unsatisfactory in the long term. The welfare system itself constrains women's employment. However, when we talk to women, they tell us that they like having a green card because they have small children who can potentially be sick a lot. They need food stamps. While welfare benefits are low, it is sometimes better than their options in employment.

The economic situations of the male partners of these women are equally tenuous in many of these impoverished neighborhoods. The men may be unemployed, underemployed, or involved in various underground and informal economies. Clearly, the economic instability of men mitigates against stable relationships. However, we do find that some of these men are quite active in women's lives and in the lives of their children. We do not always pick that up in some of the more structured measures that we may be using.

The situation of children in these families is revealing. When looking at child care patterns in poor, African-American families in these Head Start programs, two broad patterns seem to emerge. There is a communal pattern of child-rearing, which is characterized by multiple caregivers. This may be mothers, grandmothers, fathers, and other kin. There also is an individualistic pattern, which is characterized by one primary caregiver. Neither pattern seems to be inherently better than the other, but depends on the specifics of the family. However, we do get a sense of the markers of good-quality communal care and good-quality individual child care. For example,

Methods for Assessing Low-Income Minority Families

good-quality communal care is characterized by various caregivers who are perceived as trustworthy. These adults who come together expand the resource base of children. They provide affective, economic, and supervisory resources. There is some consistency in caregiving expectations and behaviors. One of the major markers of good-quality individual care is that the mother feels capable of taking care of the children and their needs. In some cases, women are removing themselves from extended networks because they feel that these networks may be problematic. Being in a network is not always a good thing.

As we continue to look at the situation of children, we see neighborhood influences on child care. Parents talk explicitly about neighborhood dangers. For the most part, they are able to monitor and cloister young children within the household. Of course, this is related to the age of the children; they are very young. However, there are early indicators that some of these families will be unable to continue to maintain this pattern. Of the children that we observed, the most vulnerable children seem to be showing signs of early parental emancipation. These are the children who are taking major responsibilities for other children in the family and also performing more adult-like tasks within the household.

When we look at the role of Head Start in these women's lives, they overwhelmingly state that it is positive. For example, they talk about Head Start as being a sanctuary. It is a sanctuary for problems in the family away from dangers of a neighborhood. It provides social support. Head Start provides opportunities for these women to come together and form friendships with the other mothers, and also to form some strong attachments, in some cases, to the teachers and social workers in the programs. Head Start seems to broaden the knowledge base for some women. They talk about where to shop, where to buy secondhand clothing, what other resources are available for children. They also say that it assists in their child rearing skills. The mothers say, "I holler less; I hit less as a result of learning about various things in the program." Some of this is borne out in our observations. Head Start also helps parents to understand the developmental needs of their children. Since the poverty in these families has a tendency to encourage early maturation, this is quite important. These mothers also cite some of the positive benefits for their children. They say that it helps children separate from the family. They have fears that children may be too attached, and they want to get them prepared for kindergarten. They say the children learn social skills, how to get along with other children. They are learning their shapes, colors, and numbers. Teachers are in some cases acting as parental surrogates for children. They are aware of the children who may not be getting what they need at home and take particular care with these children, because they know the mothers may have health problems, drug problems, or other severe problems associated with poverty.

To summarize, how can this ethnographic data be used to inform Head Start programs? It is clear that Head Start is on the right track as a comprehensive program, and that it needs to continue to focus on issues of health, education, housing, and economic problems that families face. The descriptions also point to the heterogeneity of the families in these communities, and that Head Start should be attentive to the various subpopulations that use their programs. Some of the more economically secure and socially savvy parents are using Head Start as an arsenal of strategies. They need more backup and basic support. The less economically secure families, the ones that are the least savvy, need more intensive support, including how to identify and access other services. These families also need help with basic survival needs so that they can continue to participate in Head Start. There is also a need to address the problems of the communities in which these families live. One strategy that we may want to consider is to help build the neighborhood infrastructure, to use some of these parenting coalitions that take shape within Head Start to ful-

fill some neighborhood tasks. For example, Head Start parenting groups could be the nucleus for neighborhood block and watch groups.

Finally, how can we use ethnographic research to inform future research? The ethnographic literature does identify some gaps. We need more ethnographic studies across a range of settings, studies of families and children within the context of their neighborhoods and within the context of Head Start. We also need to do more observational studies of Head Start programs. This would allow researchers to explore what works in Head Start programs, what the day-to-day routine looks like, and what works under what conditions. Certainly, that is going to be a challenge given the flexibility of the programs. While my talk is focused on African-American families, we also need studies of other racial and ethnic-group families and children. Ethnographic research methods are flexible enough to discern the unique, as well as the similar, characteristics of the various populations. In closing, I want to quote from an ethnographic study of families and young children. This ethnographer speaks to one of the strengths of ethnographic research. She says, "As I got to know and to absorb a great deal about the daily routines and the physical and social context of the lives of many parents and children, the logic of many of the choices and much of the behavior of these low-income families became clearer." This is the type of clarity that researchers will need to know to address issues of families and children as we enter the 21st century.

W. Steven Barnett: I would like to review a couple of points. Greg opened up the possibility of the dangers of large-scale studies, in particular, but even for small-scale, well crafted quasi-experimental studies, where we do not have control over what is going on and the potential for measurement error is great, which applies to most of the quantitative research on Head Start? Measurement error can occur in the outcomes and in the ways we use to try to control for differences between groups. It is important to realize that this is not just random measurement error. These measurement errors are correlated with other characteristics of the families and with participation in Head Start. For example, there is likely to be correlation between errors in the PPVT and SES, or between income, as we have measured it, and true SES. Another study of the same data set has found serious measurement error in height. These data were analyzed for the impact on physical development of children, not just on cognitive development. It turns out that not only is there measurement error in height, but it is correlated with the age of the child and with SES. As income goes up, the parents are better at recording how tall their children are. That creates serious problems for estimating Head Start's effect on height.

Greg and Sue talked about issues with respect to unmeasured variables, unobserved variables that may produce bias. That leads us back to the general issue of selection bias. We know the two groups are not the same; they are not supposed to be the same. Sue presents us with a methodology for looking at the extent of the danger. Virginia focused on contextual variables, which may bring the same problems. They are important, but how do we measure them? Robin described an approach that helps us think about how we might deal with some of these problems. Are these problems so serious that our quantitative methods may not be able to deal with them? For example, if we are thinking about community, what are the important aspects of community? Those things are not well defined. In a quantitative analysis, we will be quite limited in how we can categorize people in terms of their community connections or what constitutes different types of families. We look at ethnography as a powerful tool for helping us figure out how to do that. There is a lot of interplay between the methodologies.

Methods for Assessing Low-Income Minority Families

Audience Questions and Comments

Question: What is the advantage of the propensity score as opposed to analysis of covariance or putting the covariance into a reduction?

Sue Marcus: There are two major advantages. One advantage occurs if there is missing data. For example, we have a lot of missing data about parents' education. You are still able to calculate the propensity score on the basis of the remaining covariance. You do not have to throw away any of your subjects. Also, we do not have any problem with over-fitting. You can put in hundreds of covariants, if you want, for the propensity score. The other advantage is that it is a data-reduction type of technique where you can take as many covariants as you have and come up with essentially a composite score. In this case, for Head Start, it would be similar to an SES score.

Gregory Camilli: Lee Cronbach published a paper in 1979 called "Analysis of Variance: Angel of Salvation or Temptress and Deluder?" He proposed the linear discriminant function, which is the same thing as the propensity score, for doing this type of analysis. In fact, he and Don Campbell had a long conversation about this, and so this notion has been around since Rubin and Rosenbaum's paper was published in 1983. However, the concept was there much earlier and, in fact, had been proposed in the 1960s by a fellow doing time-series analysis.

Question: If you had a good micro-ethnographic study of the PPVT in various contexts, what difference would it make?

Gregory Camilli: There is some research on the PPVT along these lines. If you read it, you might hesitate to use the PPVT in the first place. What you want to measure depends on goals and how programs are structured. An ethnographic study can help you determine the fit of different measures and different goals. This is ethnography blurring into evaluation, because the goals of evaluation are much broader than just ethnography or just experimental research. You need a broader view when you are balancing the needs for outcome evaluation in a complex situation.

W. Steven Barnett: Greg has looked at the data, and it appears that there are pretty strong differences between the African-American children and the White and Latino children. It is unclear why. Talking to people about the experience and observing the experience would help to determine whether something is going on with the testing procedures. Perhaps the administrators relate differently to the children, or the children relate differently to the administrators of the test based on ethnicity. It might be in the administration itself. On the other hand, it might be the characteristics of the test. It is unfair that the test measures the same thing across different ethnic groups. However, you cannot tell whether it is the administration of the test bearing on ethnicity, the response to the test, or the test itself. The PPVT should be a test of receptive language. If you use the Peabody Individualized Achievement Test on receptive language, you get very different results. You get much larger effects for African Americans. You do not have a floor effect. Why would that be?

Comment: I am a speech therapist and have given the PPVT many times. One of the problems with it is that it is a single word vocabulary test. As such, it is a limited measure, an old test,

Methods for Assessing Low-Income Minority Families

and culturally biased. There is a necessity to use other measures although not the ethnographic approach. We need to use more ecological approaches where appropriate. The PPVT was standardized on a middle-class, White sample. Any older language tests like it have the same problem; they are not particularly appropriate for minority or low-income children.

W. Steven Barnett: An older form of the PPVT was used at the NLS because it was cheap and easy to administer. I think Robin's point about potential of ethnography for exploring different types of measures is an important one. One of Greg's points is about the push for huge studies as opposed to small, well crafted ones. If you are pushed to do a large-scale study, given the resource limitations that Head Start has for research, what are you pushing researchers to do?

Question: I would like to hear Robin Jarret's response to the question that qualitative researchers are always asked, and that is: How do you generalize from these studies?

Robin Jarret: I was on a panel talking about using ethnographic research for public policy, and the speaker got up and said that I was brave to even say that. I did not think it was a compliment. From 1991 to 1992, I was at Russell Sage and did a meta-analysis of existing qualitative and ethnographic studies of poor families. I looked across various ethnic groups, but the literature is far more developed for African Americans. What was so vivid was the sizeable overlap across these studies; researchers were finding common patterns. Although they were looking at different substantive issues and were using different combinations of methods, what stood out, particularly around family and domestic organization, was the heterogeneity of families in these communities, particularly in family management strategies. When you look at the ethnographic literature as a larger body instead of singling out single case studies, then you are able to see more of the recurrent patterns. These small-scale case studies are important in and of themselves, because they tell us what life is like in these communities. They tell us about the categories that can be used in larger scale studies. For example, Virginia was talking about how you define neighborhood. Ethnographic studies can help us see that neighborhoods are geographical boundaries, but they are also social boundaries. When you look at the life histories and genealogies of families, you find that they have connections across neighborhoods and that they may not be, as poor people are sometimes, living in isolated communities. Another example is the issue of what a family is. We see it in the literature from the 1950s and 1960s of studies of African Americans in the United States. The Caribbean just made some fundamental discoveries about defining domestic groups that we still find today; that is, female-headed households. There are lots of reasons for people to conceal how they live. Even small-scale studies can help us more clearly understand domestic groups so that researchers may use this information to make the quantitative measures far more accurate.

Question: In a study where you have Head Start versus non-Head Start within a community, is there a way to assess whether the effect of Head Start in the community may be affecting the non-Head Start population? To use a researcher term, there is the potential for "contamination" of positive effects on communities and families. How do you do this kind of traditional, experimental paradigm within a community?

Robin Jarret: It makes a randomized, clinical trial extremely difficult to do in a community. The irony about it is that the goal of Head Start is to vitalize a whole community. Therefore, it

Methods for Assessing Low-Income Minority Families

makes it exceedingly difficult to do a randomized trial. I am not so sure at this point that I would advocate a randomized trial of that type at all. If you have done what you are hoping to do, you have contaminated. One might also take into consideration where these children go after they leave Head Start. An example is doing a longitudinal follow-up to consider the multiple additional sets of influences on their lives. That does not solve the problem of contamination, but it permits the different approaches to research with Head Start children to be blended for considering other additional effects.

I resonate to the comments about the Currie and Thomas work. When it was reported in *The New York Times*, the point was that effects washed out for the African-American children, but did not for the White children. I remember thinking that the children are in entirely different school situations. How could one even report that without thinking about what is responsible for so-called washout? The point you raise about contamination should be faced carefully in most of this work.

■ Building Bridges among Researchers, Communities, and Policymakers: The Role of Program Evaluation in Addressing the Needs of Adolescent Mothers and Their Children

Chair: Dominique Treboux

Discussant: Richard M. Lerner

Presenters: Commissioner John B. Wingate, Marcia K. Spector, Dominique Treboux

Adolescent mothers are at high risk of dropping out of school and being unmarried, and their children are likely to suffer the consequences of living in poverty, including difficulties in school and poor health care. Based on an understanding of human development as a set of changing interrelations between the individual and his/her multilevel context (e.g., family, neighborhood, society), a developmental, contextualist view has been advanced to integrate research, community programs, and social policymakers in addressing the problems facing children, youth, and families. This perspective requires both a multidimensional and multidisciplinary framework for prevention and intervention programs, and interdisciplinary collaborations between researchers, communities, and policymakers.

Program evaluation is a common denominator among researchers, community agencies, and policymakers; the guiding rationale for evaluation is that it provides information on the effects of programs on development, and informs social policy decision-making. Lerner and colleagues have argued that one cannot evaluate a program independent of its context, and the stakeholders involved in the program must take a participatory role in the evaluation. The sharing of perspectives should insure a formulation of research questions and measures and designs that are policy relevant, inform researchers about person-context relations, and support effective prevention and intervention efforts.

This symposium presented three perspectives on evaluation research with adolescent mothers and their children. From the social policy perspective, Commissioner John Wingate, Department of Social Services, outlined the current public programs affecting families headed by adolescent mothers and the role of program evaluation in policy decision-making. From the community perspective, Marcia Spector, the director of an adolescent pregnant parenting networking organization, provided an overview of programs and results from an ongoing evaluation. From the research perspective, Dominique Treboux presented results from a program evaluation based on contextual models of development.

Richard Lerner presented the Development-In-Context Evaluation model (DICE) as a useful model for integrating the various perspectives on program evaluation. Moreover, Dr. Lerner stressed the importance of engaging all stakeholders, including program participants, in the particular programs in 1) planning the evaluation, 2) decisions regarding the nature of any preliminary, developmental, and outcome information sought about the program, 3) collection of relevant data, and 4) documentation and interpretation of the information derived from the evaluation. Evaluation research requires the integration of specific goals and values in communities that shape the program.

A Social Policy Perspective on Program Evaluation *Commissioner John B. Wingate*

Presently, the most direct threat to adolescent pregnancy and parenting programs comes from state budget cuts. Programs for adolescent parents seem particularly vulnerable because they are expensive to operate and difficult to evaluate. Without evidence that programs are effective, policymakers are in a difficult position to advocate for their maintenance.

Program Evaluation

Suffolk County, NY, has many excellent programs designed to assist at-risk and parenting teens. Among these programs, the Teenage Services Act (TASA) stands out for its efforts to assist pregnant/parenting and at-risk teens while promoting self-sufficiency. In 1984, New York State passed the Teenage Services Act to assist pregnant and parenting teens who are identified prior to their 18th birthday and receiving public assistance. TASA case management services are offered to each eligible pregnant or parenting teen, male or female, for the purpose of providing access to services, assisting with problem-solving and promoting economic independence and self-sufficiency of the individual or family members. As long as the public assistance case remains open, the client is entitled to receive services until she/he reaches her/his 20th birthday. The aim is to reduce the long-term dependence on public benefits. Based on Social Services Law SS20(3)(d), 34(3)(f) and 409-k(5), Part 361 of New York State Department of Social Services regulations specify that the purpose of TASA Case Management is to "maintain and strengthen family and to retain the capability for maximum self-support and personal independence." Accordingly, provision of sound TASA management services should generate various client outcomes that would logically result in achievement of the purposes of the legislation.

Under the TASA program, eligible teens are routinely identified by the Department of Social Services, public health nurses, school personnel, and hospital social workers. The Suffolk County Department of Social Services contracts with four agencies to provide TASA case management services. During the New York fiscal year ending March 31, 1996, the agencies received a total of \$332,345 in federal, state, and county reimbursement for case management services provided to some 160 clients.

From our perspective, the question is whether we got value from the \$332,345 invested in TASA last year. We do not know the answer. To date, there has been essentially no TASA program evaluation. For the most part, we are interested in certain benchmarks that would reflect what we would consider a healthy family life and economic independence. Thus, for example, in terms of "maintaining and strengthen family life," such benchmarks or outcomes should include improved pregnancy outcomes, reduced substance use, decreased incidence of repeated pregnancy or sibling pregnancy, reduced sexually transmitted diseases, and fewer abortions. In terms of self-sufficiency, desired outcomes include a reduced reliance on public assistance, an increase in level of education (fewer drop-outs), an increase in housing stability, fewer children placed in foster care, and greater employment. Estimated dollar savings to government would be desirable for each benchmark. As such, program evaluation including cost-benefit analysis is essential. Such evaluation which requires controlled experiments and an unbiased analysis of results would benefit from the involvement of university-based researchers.

A Multifaceted Community-Service Approach *Marcia K. Spector, Patricia Pearson*

This presentation looked at a multifaceted community approach to addressing the needs of adolescent mothers and their children in the South Brookhaven area of Suffolk County. The goal of the program is to reduce the number of first and subsequent pregnancies, to promote self-sufficiency and concrete goal setting, and to help adolescents foster healthy relationships with their partners and children.

The program initiative, funded through the New York State Department of Social Services, began in 1988, with grants awarded on a competitive basis to communities based upon levels of adolescent pregnancy, poverty, single parent households, and other demographic indicators. With its strong emphasis on structuring coordinated comprehensive service systems where fragmenta-

BEST COPY AVAILABLE

tion and duplication exist (prevention, the creation of opportunities for self-sufficiency, and broad community involvement), funded communities determine their own program needs and the roles of local agencies in program delivery. Formal interagency agreements link funded agencies with other local providers, and a community advisory board provides oversight and makes annual funding decisions.

Five local youth-serving agencies provide specific, uniquely tailored services for pregnant, parenting, and at-risk adolescents, including school and community-based prevention education, medical support and social work services, counseling and case management, after-school recreation, crisis intervention, mentoring, and the provision of basic-need maternity and infant items to indigent adolescent mothers.

The grant has a computerized data-collection system that tracks individual client status, interventions, and any resulting changes. The information collected represents a snapshot of the client's situation at the time of entry into a program and at three-month intervals thereafter until she/he is discharged from the program. Ultimately, the system will make it possible to more effectively track who the teen is, identify her/his initial needs, provide services based upon those needs, and help providers develop more individualized service plans that are more likely to reach the desired outcomes.

Data from the 24 Adolescent Pregnancy Prevention and Services Projects, including the South Brookhaven Community Service Project, were compiled by the New York State Council on Adolescent Pregnancy (NYSCAP). Data examined client participation and client characteristics at intake and discharge, during the 12-month period ending June 30, 1995. Their outcome measurements also looked at implications for cost savings. In the South Brookhaven project, 88 teen parents graduated, 47 percent were employed at the time, and fewer than 1 percent dropped out of school. There were no foster care placements for the approximately 300 children of teen parents enrolled in our program. Of the 318 teens served by the Health Center subcontractor, 95 percent indicated that they had no other routine health care provider.

In terms of implications for cost savings, we estimate that for every parent who completes high school and is not dependent on public assistance, Suffolk County saves \$13,052 annually on AFDC and Medicaid costs. Each foster care placement that is avoided saves Suffolk County as much as \$15,000 in annual costs. Each visit that a teen makes to the Health Center for preventive or prenatal care saves Suffolk County as much as \$7,000 in additional hospital admissions costs.

Integrating Developmental Psychology into Program Evaluation

Dominique Treboux, Zvi Strassberg, Charlotte Wang, Judith A. Crowell

For the most part, policy research has been the domain of all disciplines other than psychology (e.g., political science, economics, sociology, and social welfare). Because these disciplines tend to emphasize contextual factors (social and economic factors) in human development, policy research has tended to ignore child development research. However, because developmental psychologists stress individual psychological factors and their integration into social contexts in their conceptualizations of human development, child development research has much to offer policymakers. Thus, in order for social policymakers to benefit from developmental research, such research needs to demonstrate the applicability of multilevel and multidisciplinary models of human development for addressing social policy issues. Consistent with this view, this research was initiated with the evaluation of the effectiveness of adolescent parenting community programs, integrating social-contextual and individual psychological factors.

Program Evaluation

Our conceptualization of research evaluation is based on a contextual model of development that views human behavior as being determined by multiple influences. These influences, such as biological, psychological, and social factors, are deemed to be interrelated and dynamic. Change on one level of influence would produce change on another level of development. For example, an adolescent mother's ability to parent is influenced by a number of factors, including characteristics of the child, her current interpersonal support system (i.e., partner, mother) and socioeconomic factors. The community center is viewed as influential on the young mother and her child by virtue of the fact that it provides both emotional support (i.e. parenting support, education, counseling) as well as instrumental support, such as providing clothing, diapers, referrals, etc. At the same time, the effectiveness of the community center or its use will also be influenced greatly by the characteristics of the mother (i.e., depression, motivation). The influence of policy is seen primarily through services offered to young mothers. This model suggests that change in any one area, such as policy, could produce change in other areas (i.e., programs offered at community centers, mother's psychological functioning).

To test this model, we have collaborated with three sites: one alternative high school for pregnant and parenting adolescents and two community agencies. Consistent with a contextual model of development, the assessments were broken down along the following dimensions: 1) The individual-psychological dimension, including adjustment variables (depression, stress, cognitive readiness); 2) the social network or interpersonal context (relationships with and/or support from own mother, partner, and child); and 3) the community context. All measures have demonstrated validity and reliability.

In this paper, we focus on mothers' psychological functioning and parenting ability. Over the first nine months, approximately 20 percent of young mothers dropped out of the program(s), and depression was found to be the most significant predictor. Likewise, depression was related to feelings of stress, perception of the child as stressful, and reported difficulties in responding to the child's needs. At the second assessment, mothers reported fewer stress symptoms and tended to view their parental role as being less stressful than at first assessment. Thus, psychological functioning appears to act as a linking component between social-contextual variables and program goals. Our modest demonstration suggests more broad application of psychological-contextual models for assessing program effectiveness and informing policy decisions.

■ Collaborative Approaches to the Evaluation of Family Support and Preservation Programs

Chair: Cynthia Guy

Discussants: Karl Dennis, Jennifer Zanger

Presenters: Deborah Daro, Michael Epstein, Brenda McGowan

This symposium focuses on the process, challenges, and rewards of conducting collaborative program evaluations in which program operators and researchers jointly design and implement the study. In each of the three program evaluations described below, program managers played a lead role in initially defining evaluation issues and selecting evaluators. Program managers and staff then entered into a three-year partnership with the evaluators, working together to develop a comprehensive evaluation plan, design instruments, collect data, and interpret findings.

These collaborative studies are supported by the Annie E. Casey Foundation through the Evaluation Grants Program, an innovative funding initiative. The initiative funds evaluations of resilient, well established programs that embody key dimensions of effective child and family services. Programs selected to participate in the Evaluations Grants Program are comprehensive, community based, family focused, and take a preventative approach to child and family services. By supporting evaluations of such exemplary programs, the Foundation pursues a number of goals. One goal is to advance the field of child and family services by producing credible information on the operations and outcomes of exemplary programs. These data will be used to inform policymakers, administrators, and funders about approaches to child and family services that merit expansion, replication, and support. In addition, by involving program operators in the creation and refinement of research tools, the Evaluation Grants Program promotes the development of new evaluation methods, grounded in the complexities and realities of innovative family services. Finally, these evaluations are intended to provide administrators and line staff with information that they themselves identify as important and useful to program management and service delivery.

The papers below describe collaborative evaluations of three family support and preservation programs funded under the Evaluation Grants Program. They include 1) the Center for Family Life in Sunset Park, a Brooklyn-based program that offers a broad range of services to neighborhood children and families; 2) the Ounce of Prevention Fund's Center for Successful Child Development, also known as the Beethoven Project, a multiservice program serving children and families in Chicago's Robert Taylor Homes; and 3) the Satellite Family Outreach Program, a family preservation and support program operated in Chicago by Kaleidoscope, Inc. The research efforts, which began in 1993, have produced tension and disagreement between program staff and evaluators, as well as consensus, partnership, and progress. Throughout, the process of collaborative evaluation has been marked by an intensive involvement of researchers and program staff, as they work together to create studies that are both rigorous and relevant.

Evaluating Established Programs: Challenges and Opportunities *Deborah Daro*

The Annie E. Casey Foundation selected the Center for Successful Child Development (CSCD) as one of four programs to participate in the Foundation's Evaluation Grants Program in May 1993. Under this initiative, each of the participating programs were instructed to select an evaluator to conduct a comprehensive assessment of their program operations and outcomes. In October 1993, CSCD selected the Center on Child Abuse Prevention Research, a program of the

Program Evaluation

National Committee to Prevent Child Abuse (NCPCA), to conduct their comprehensive evaluation. After consultation with both the Ounce and CSCD personnel, NCPCA submitted a proposal that outlined the study's research questions, methodology, and analysis plan. The evaluation's primary goals are to clarify the characteristics and needs of the program's target population; articulate those outreach and service strategies most successful in engaging and retaining participants; identify realistic and attainable outcome measures for services targeting high-risk families; and provide guidance to CSCD, as well as to the early intervention field on how best to structure programs to maximize gains.

Throughout the evaluation, particular emphasis has been placed in engaging CSCD line staff in the study's development and implementation. This presentation reviewed the strategies employed in creating an effective evaluation process and useful evaluation products. Although the study is not yet complete, a number of important collaborative lessons have been identified in finalizing the evaluation's design, revising the staff assessment protocols, and selecting standardized instruments relevant to the population under study. These initial efforts, coupled with the development of two preliminary reports, have suggested the following procedures may be particularly useful when implementing program evaluations within an ongoing, well-established family support program: 1) at least one evaluation team member should attend critical staff or management meetings; 2) a system should be established to regularly review the evaluation's progress and provide a forum in which negotiated solutions for all difficulties can be achieved; 3) evaluators need to consider the program manager as full partner in the evaluation, and provide technical assistance to the program manager in interpreting final data or evaluation products; 4) evaluators should work with staff in identifying variables of greatest interest to them, and work with all interested parties to design a doable and reliable data-collection system; 5) evaluators need to strive for a balance between closeness with staff and scientific objectivity; 6) evaluators need to identify their "ideal" evaluation model, and work with program managers and staff to create a useful and appropriate design; 7) evaluators need to recognize the value of using positive indicators of change rather than focusing on measuring a reduction in negative attributes; 8) evaluators need to place an emphasis on demonstrating for program staff the utility of specific measures from the providers' point of view (e.g., how will knowledge of change regarding a certain construct help service providers better meet the needs of their families?); and 9) evaluators need to keep data collection to a minimum, particularly if program staff are collecting the data. The more data collected by staff, the less reliable the data-collection system.

Evaluation of the Satellite Family Outreach Program: A Collaborative Approach to Evaluating a Child Welfare Program in an Urban Setting *Michael H. Epstein, Jennifer Soderland*

Kaleidoscope, a child welfare agency in Chicago, received a grant from the Annie E. Casey Foundation to evaluate its Satellite Family Outreach Program. Satellite is a family preservation program whose primary goal is to reunite children returning from residential care with their natural parents and to help maintain referred children, parents, and siblings as an intact unit. Satellite has about 25 professional staff that serve approximately 60 children and families. The individuals served are referred from the Illinois Department of Children and Family Services and are among their most challenging clients. The services provided through Satellite are based, in part, on the philosophy of wraparound care, including unconditional care, intensive case management, individual planning, family involvement, flexible funding, and cultural competence. The purpose of

this presentation is to describe the collaborative process that led to the development and implementation of the evaluation.

The evaluation has been a collaborative effort between Satellite staff and the evaluators. In order to develop the overall evaluation plan, an evaluation team was assembled that included the Director of Satellite, the Assistant Director, a social worker, a family worker, and two evaluators. Over a three-month period, this group met on 12 occasions to develop the plan. Based upon the evaluation components identified by the Annie E. Casey Foundation (i.e., background, operations, process, outcomes), the specific evaluation issues noted by Kaleidoscope (i.e., wraparound philosophy, staff activities, outcomes) and the experience of the evaluators, the evaluation team identified three overriding questions to pursue in the evaluation plan. Who are the children and families served by Satellite? How are the children and families served by Satellite? How well are the children and families served by Satellite? Each of these questions has its own set of subquestions (a total of 17 subquestions were identified), methodological strategies, and data-collection measures, responsibilities, and schedule.

In light of the unique services provided by Satellite and the challenges presented by their clients, several instruments had to be developed for the evaluation. The instruments were designed to assess the behaviors of children and adults (i.e., Weekly Adjustment Indicators), staff activities (i.e., Professional Activities Checklist), and children's strength (i.e., Scale to Assess Behavioral and Emotional Skills). In developing these instruments, Satellite staff were responsible for identifying important behaviors/items to include, providing feedback as they were developed, and piloting the instruments. The evaluators were responsible for constructing meaningful measures and implementing procedures to determine validity and reliability. Each of the measures met acceptable psychometric properties prior to being implemented.

The evaluation has been ongoing for two and one-half years. In this period, the Satellite staff has been providing the required data on a regular basis. The staff's commitment to data collection can be increased by 1) allowing staff to have input when the plan is being developed; 2) providing staff the opportunity to provide feedback as the evaluation is implemented; 3) making changes based on staff input; 4) returning evaluation data to staff on a regular basis; 5) hiring an on-site data collector; 6) attending staff meetings regularly; 7) summarizing evaluation reports and returning them to staff; and 8) paying staff for data-collection tasks.

The Community School Program at the Center for Family Life: A Multifaceted Study

Michael Botsko, Peg Hess, Brenda McGowan

This paper discussed the practitioner-researcher collaboration and some of the obstacles involved in designing and implementing a multifaceted, three-year study of the Center for Family Life, a comprehensive, neighborhood-based family service program located in the Sunset Park area of Brooklyn. The presentation focused on the research conducted at one of the three public schools where the Center provides services.

This community school program, which serves over 700 youth annually, offers a wide range of services such as after-school care, summer day camp, tutoring services, a teen evening center, parent workshops, and family socialization and recreation activities. It also includes a youth development program, Project Youth, for teenagers who help with the younger children in the after-school and summer camp programs.

A number of approaches were used to learn about the community school program and the dynamics of its various components. These included intensive taped interviews with key program

Program Evaluation

and school personnel; focus-group meetings with parents and youth participants; program observations; multiple brief interviews with children and youth staff; a telephone survey of parents; and administration of standardized measures of self-esteem and locus of control to participants in Project Youth.

The administration and staff of the Center were involved in decision-making at each step of the research process. This collaboration helped to insure that the researchers were asking the right questions and obtaining valid data. However, close collaboration does not eliminate many of the inevitable conflicts between mandates of research and practice. The paper concluded with a discussion of some of the major obstacles.

Perhaps the biggest challenge was the effort to translate program objectives and interventive processes into discrete, measurable concepts. Program achievements that are meaningful to staff are not easily translated into hard program outcomes that demonstrate the efficiency of a particular service strategy in reducing specific social problems.

Some of the other research challenges encountered were identified as follows: 1) the Center was experiencing ongoing changes in political environment, program organization, staffing, and service strategies even as it was being studied; 2) there were unanticipated delays and difficulties in gaining direct access to clients; 3) the demands of the research project were more labor intensive than program administrators originally anticipated; and 4) staff members were somewhat resistant to spending time on research tasks that could—more profitably in their view—be spent on direct services to clients.

Despite these obstacles, this collaboration has been very stimulating for two reasons. First, since the agency had essentially invited the research, the authors had to abandon the traditional tendency to blame practitioners for their resistance and consider alternative explanations. This forced more open acknowledgment of the very different imperatives of practice and research.

Second, this lengthy, intensive study encouraged much more qualitative research than is customarily feasible in program evaluation. This has facilitated greater understanding than usual of how clients view the actual services they are receiving and clearer identification of the key variables that contribute to the Center's exemplary reputation.

■ Assessing Program Quality

"Conversation Hour" with Sue Bredekamp, Gayle Cunningham, Marce Verzarro-O'Brien, William Fillmore, Jr.

Sue Bredekamp: I am the Director of Professional Development for the National Association for the Education of Young Children (NAEYC). This session will be a conversation about measuring program quality. We are going to frame the conversation around two initiatives to measure program quality particularly available to Head Start now and to the entire early childhood field: the NAEYC accreditation system and the National Head Start Association's Quality Initiative. We are going to talk about the pros and cons of each approach and the ways to improve and strengthen them in order to meet the needs for measuring program quality in the future.

We have two people today who have firsthand experience with these systems. Gayle Cunningham, Head Start director from Birmingham, AL, has many NAEYC-accredited programs. Gayle's programs have not been recognized yet by NHSA through the Quality Initiative, but she did participate in the development and review for NHSA's Quality Initiative. William Fillmore, from Pinellas County, FL, is a Head Start Director whose programs are NAEYC accredited and NHSA-quality recognized. Marce and I will begin with an introduction and overview, and then we will turn to Gayle and William, who will speak of their firsthand experiences.

We have had the NAEYC system of accreditation for 10 years. This has been a year in which we have spent some time reflecting on and evaluating where we have been and where we are going. This year, we published a book called *NAEYC Accreditation: A Decade of Learning, and the Years Ahead*. It is a good summary of what we have learned and what research has told us to date about NAEYC accreditation. It then raises some questions about what we still need to know and where we are going in the future.

I want to start by emphasizing that NAEYC could not have developed an accreditation system if it had not been for prior work done by Head Start, particularly around the Program Performance Standards and the CDA credentialing system. Those two systems were the major foundation that we looked to as we developed our standards. Also, from the beginning we developed a system to measure quality in the diversity of early childhood programs: child care centers and prekindergarten programs with a variety of sponsorships. Some were half day; some were full day. At the time, few existed in public schools, but now there are quite a few. There are programs that serve infants and toddlers through school age. There is public school kindergarten. Therefore, there is a range of programs for which we developed standards.

We basically developed standards that address classroom quality, the quality of the child's experience. Certainly, the standards themselves address other components that predict classroom quality: the staffing, staff qualifications, administration, the physical environment, all the structural variables that if not in place make it more difficult or less likely to provide good quality. If in place, they predict good-quality experiences for children in the classrooms, but they do not guarantee it. The quality of children's experience is still going to be determined by what goes on in the classroom, within the program, in the relationships among children, between adults and children and families and children.

We consider our emphasis to be on process quality, which is more difficult to measure, but which accounts for the quality of children's lives on a daily basis, and for outcomes for the future. We find that things that predict children's outcomes include learning and positive social and emotional development within the classroom, the quality of their relationships and interactions, their language interaction, the kind of curriculum that is provided, the degree to which it is appropriate for the age of the children, and so forth. We have thought about structural variables

Program Evaluation

because of their role as predictors of what goes on in the classroom for children. As we have had many years of experience, we have started to recognize that it is difficult to provide and maintain the kind of quality interaction that we are looking for with NAEYC accreditation without placing a greater emphasis on the infrastructure that makes it possible. With the current data, such as the information from the Cost, Quality, and Child Outcomes in Child Care Study, which substantiates through systematic empirical research what we have seen on a daily basis for 10 years, we see that the regulatory context of the state makes it more or less difficult for a program to provide the level of quality that we are looking for in NAEYC accreditation. The economics of competing within certain regulatory contexts make it very difficult to provide quality services.

The other issue that we have been struggling with is the reliability and validity of the system; that is, the ability to provide a system that meets a national standard within varying contexts. What has been particularly valuable about Head Start is that not only does Head Start have a set of national Performance Standards, but it has a national, equitable system for funding the delivery of those standards. That does not mean that it is funded sufficiently. That is a tension that the Head Start community has to grapple with. If you costed out what it would mean to fully comply with Performance Standards, programs' funding levels would be insufficient. However, in NAEYC's framework, where we are operating with a range of programs that are differentially funded, many of which are funded solely on the basis of what parents can pay, there is a greater tension and a greater challenge in setting a national standard. This standard has to be implemented in a large contextual range with an enormous, varying economic base. Therefore, it becomes even more difficult to provide quality.

We are trying to determine where licensing standards fit in relationship to accreditation standards. We have always said accreditation standards are above licensing standards. Licensing standards should be the minimum that everyone must meet. However, our data indicate that in some states licensing standards are not set at an acceptable level. In fact, the licensing standards in some states are at a level of quality for children that is unacceptable and potentially harmful. Therefore, when we come in and do accreditation in those contexts, accreditation standards are at a much higher level than licensing, but what our validators' eyes see when they walk in is a program that is much better than licensing, but it may just be acceptable. That creates a great deal of tension in a system that is presumably a national system. In other states where the floor is clearly set at good enough, people look for good. They probably demand it in order to observe and rate that quality for accreditation at that higher level. The challenge for NAEYC is to maintain the quality and integrity of our decisions across those diverse contexts.

Some people have said that we should never accredit a program that deviates from the standards in any way. We know that if we held 100% compliance as our standard—and this is the same situation Head Start runs into with Performance Standards—many people could not meet that. If an accrediting system is unreachable and unrealistic, then it is not defensible. It is not achieving its fundamental goal, which is not just to recognize the select programs that are in compliance, but to raise and improve overall quality. We want all children, not just some children, to have good-quality experiences.

These are the challenges we are facing as we move into the next decade. We are reviewing our criteria, even as we speak. We have been accepting suggestions from the field for making changes in the standards. We have received some good recommendations, which will go a long way toward making NAEYC accreditation standards more congruent with Head Start Performance Standards and conceptualization. For example, we received a strong recommendation from many sectors to improve our section on staff/parent interactions. It is currently framed

as a traditional, one-way communication where the professionals have their knowledge and communicate to the parents about what is developmentally appropriate. We have had a lot of input on the need to recommend that these be more reciprocal relationships. It is impossible to provide appropriate and high-quality programming unless parents are joint partners with staff. The staff are learning from parents about their individual children and about making the programmatic experience a culturally congruent one for children. This is one example of the field helping us frame the improvements that need to be made in our standards.

Our staff initiated the conversation of whether or not NAEYC standards should expand to cover comprehensive services the way Head Start programs do. We have always limited it to what has traditionally been the education portion of the Head Start Performance Standards. Currently, the decision has been to strengthen the standards in many ways, such as changing our approach to parent relationships and improving the connections between the program and the community. However, we hesitated to go beyond that to assessing comprehensive services for a couple of reasons. One is that as long as our biggest challenge is to get reliability from our validators, who are essentially qualified in early childhood, asking them to evaluate services and decide whether or not services should be provided in certain conditions, and whether they are quality services, would go beyond their area of expertise and capacity. Our other concern was that it would be difficult for NAEYC to judge which programs should be required to provide comprehensive services. There is a range of programs now that call themselves Head Start-like, and they are not. They are only like Head Start in that they serve a Head Start-eligible population. They are not like Head Start in the delivery of services. Some people have suggested NAEYC standards should more broadly address what it means to be Head Start-like, so that if programs claim to be Head Start-like, they are indeed like Head Start. We have hesitated to do this because it would be difficult for us to make judgments about which programs met those component standards. As it is now, we have difficulty making sure that all eligible aspects of the program are put forward for NAEYC accreditation.

Marce Verzarro-O'Brien: The National Head Start Association in 1990 had a Silver Ribbon Panel that looked at where Head Start ought to go in the future. The panel agreed that there needed to be a role for NHSA in promoting practices of high quality in Head Start. As a result of that work, NHSA and the board opted to promote quality in two complementary ways. The first one is a new report called "Investing In Quality Revisited." It is a report that Gregg Powell and I have put together that turned out to be quite powerful, not because we are powerful writers, but because the data are powerful. The report began as a review of how Head Start programs have used their quality set-aside money from 1990 to 1995. We used a response survey from programs. In the context of putting the report together, we reviewed a number of other studies and linked what programs did with their quality money to benchmarks of quality. In other words, if certain things are in place like staff/child ratios and staff performing jobs for which they have been trained, there exists better predictors that quality will be in place. An interesting picture of quality in Head Start emerges from the data. The bottom line is that Head Start programs did invest a great deal in indicators of quality with their quality money. There is a higher number of compliances with Performance Standards between 1990 and 1994. Another interesting artifact we found is that since 1971 there has been a steady decrease in the adjusted-for-inflation-rate cost per child in Head Start. We have just caught up with where we were in 1971 with the investment of dollars since 1990. One of our initiatives at NHSA was to gather data like this. It presents the picture of

Program Evaluation

quality to not only all of us in the Head Start community, but also to the political and other broader communities.

The other initiative we have undertaken is the Quality Initiative. After a lot of deliberation, NHSA decided that programs of poor or average quality ought to be the purview of the federal government. NHSA ought to focus on spotlighting those programs that go beyond average, that do the job excellently, and from which we all might learn how programs get to the point where they deliver services that are above a certain baseline standard. Head Start Performance Standards are that baseline. As a result, we developed a two-tiered initiative that recognizes programs of achievement and programs of excellence. Those two terms have a specific meaning to NHSA. Programs of achievement are Head Start programs that are in compliance with Performance Standards as determined by their last ACF review. Some programs come through those reviews in total compliance, and others do some negotiating and changing of policy and procedure and then come into compliance. Beyond that point, programs of achievement present evidence in writing, on tape, on video, on a number of attachments that demonstrate meeting over 130 quality indicators in 10 program areas. The 10 program areas are education, social services, parent involvement, health, disabilities, administration, transition, component integration, multiculturalism, and collaboration and advocacy. We developed the indicators with the input of the Head Start community, both immediate and extended. An indicator may be, for example, that a transition plan is in place that spells out the responsibilities of both the Head Start program and the public school program for transition of children and families from Head Start to public school. Materials that document that a program meets those indicators are submitted to a review panel comprised of members of the immediate and extended Head Start family.

The second level of the NHSA Quality Initiative is programs of excellence. It was our sense that there exist programs in Head Start that not only meet these indicators, but that respond in very creative ways to the specific challenges of their communities. They have come up with initiatives that might not work in Buffalo, NY, but might be wonderful in Pinellas Park, FL, and vice-versa. In addition, these programs, throughout the years, have been so strong that they can demonstrate that they have had meaningful short- and long-term impact on the communities they served. The communities are not only their geographical communities, but also their staff, the political communities in which they exist, and so on. A program of excellence takes years to develop, so the impact is long term. Therefore, to programs that are viewed to be achieving programs, we have offered the opportunity to go to the next step, to show the special initiatives and projects they have developed, to present why and how they were developed, and to demonstrate the impact on the communities served, short and long term. To do that, we ask applicants to first respond to suggestions that the panels rating the achievement programs gave to those programs. Then we ask them to demonstrate the special initiatives developed over the years and the impact they made. To insure the broader community that it was not just a program on paper, programs of excellence also receive an on-site visit from a staff person and at least one other member of that particular review panel. These visits are not like regional office reviews. They are extremely targeted. It is an opportunity to dialogue and share.

We have currently three programs of excellence in the country. One is Davis Morgan, in Summit County, UT. It is a suburban and rural program of approximately 400 children, just outside Salt Lake City. It has a Parent and Child Center as a piece of its operation, and it is a public school grantee. The second is Ninth District Opportunities in Gainesville, GA, serving 20 counties northwest of Atlanta. There are about 2,000 Head Start children and 2,000 state pre-K children who receive the same level of service, so you would not know which children in the centers

are funded in which way. That is a Community Action grantee. Third, there is Pinellas Park, on the western coast of Florida, which is Mr. Fillmore's program, with 1,300 children. It is a delegate agency of a Community Action grantee, and it is a full-year/full-day program. I give you all this data to tell you that what we are finding is quality that is not driven by the type of grantee, the size of program, or the size of its geography, that is, jurisdiction. It is driven by a strong, well developed management team with a charismatic leader at the head, who has been in place for a number of years. These are the consistent variables that we are finding in all of the programs.

That also holds true for our three programs of achievement. Upper DeMoines Head Start in Gretinger, IA, is a seven-county program of about 300 children. Miami Dade Community Action agency program is a program of about 5,000 in a multicultural, multiracial area of Dade County, FL. It is a Community Action agency, but a different Community Action agency. It is a county government agency. In Lee County, FL, in Fort Myers, there is a public school grantee that also has state pre-K money. There is a wide range of programs there also.

Gayle Cunningham: I am going to talk about the process that we have gone through to accredit 34 Head Start centers in Birmingham, AL, and thereabouts, and talk about that in the framework of total program quality improvement. I was fortunate enough in 1985 to be in one of the first groups of validators that was trained in the NAEYC accreditation system. I had the opportunity to do a couple of validation visits not too long after that training. I also had the opportunity to become the Director of a Head Start program in Birmingham. The program at that point was in need of about everything and considered seriously high risk. It had about 600 children with a Parent and Child Center in addition to the Head Start program. It gave me the opportunity to try out things I had been advising others to do for many years.

I moved to Birmingham and began working with the program. My goal was to first bring the program into compliance with Head Start Standards, and then to reach beyond that to NAEYC accreditation. It took longer than I thought because of Head Start expansion. We were required to find other opportunities for serving children. As a result, we expanded from about 600 children to about 1,100 children during that time. When I started, we were in 12 sites, all of them center sites, but mostly in churches. I immediately moved out of church-based sites that were proving to be quite difficult to manage and into school buildings we were able to obtain from the school system. We moved down to six sites. Then in 1990, we began placing our Head Start centers in public schools. We expanded from 6 centers to 35 centers. In the process, we formed wonderful partnerships and collaborations with six different school systems. Our children can walk to the centers, and it makes a big difference. They are walking to centers that they will continue to use in kindergarten and elementary school.

We were fortunate to have the advantage of receiving quality-improvement funds. We used them in a variety of ways. First, we lowered staff/child ratios. Our classrooms are officially 17-child classrooms, but we moved from what had been 20-child classrooms. We decreased our family service worker caseloads to two classrooms per worker. As we look to the future, we are looking at some other changes in the way that we provide family services and social services in order to ensure that those who need us most get the most attention.

We also increased our internal training capacity. All programs that are growing, vibrant, and serving children need to have ongoing training as a centerpiece. As a result, we have two education coordinators, three education specialists, a huge resource room for our teaching staff, and more for all of our staff, because we are developing collections of social services and health services for parents. There is a huge resource room that allows teachers to get the help they need

Program Evaluation

to develop curriculum, to support themselves in college classes that we encourage them to participate in, and to help them through their CDA training. We have made clear requirements for staff about obtaining CDAs well ahead of Head Start's expectations. We required CDAs, and now, Associate Degrees, for teaching staff. All of this is aimed at meeting NAEYC's accreditation criteria.

Probably one of the more costly aspects of our preparation was having appropriate playgrounds for children. When we faced 35 playgrounds as opposed to the 6 we originally thought we would be putting in place, it was a challenge. However, we made some creative use of our quality improvement money, as well as some local funding. We have installed early childhood playgrounds at all of the public school sites where we serve children and made those playgrounds available, not just to our Head Start children, but to the younger grades at all the schools.

All of that was from 1986 to 1994, when our first 13 centers were accredited. It was a long haul and a lot of hard work. The next year we had 16 more centers accredited, and we just learned of another 5 that have been accredited. In 1992, we obtained the assistance of Quality Assist, a company in Atlanta that has developed an instrument called the Assessment Profile, which helped us get organized in regard to staff training and determining what additional needs we had in order to reach accreditation. We found that their help and the use of their system to determine what our training needs were made a huge difference towards achieving accreditation.

Last year, we began looking at the NHSA Quality Initiative and started thinking about how we would seek that honor. We have the goal of submitting our application for programs of achievement this fall. All of this has fit neatly together, and I see these as steps towards quality. We have the good fortune of being one of three programs attached to Georgia State's Head Start Quality Research Center, giving us the opportunity to use data about our program to continue our efforts to maintain and improve the quality of programming for children. We have just gone through another round of assessments of our classrooms using the Profile instrument. We already have the findings and a training plan for next year based on the needs that were identified.

We recently had the opportunity to work with another program in Alabama that is having some problems and called to say they need to see a five-year plan and would like a copy of ours. I said that we never had a five-year plan, but suggested they look at state licensing standards, the Head Start Performance Standards, NAEYC's accreditation criteria and system, and NHSA's Quality Initiative. If you develop a plan to achieve compliance with all of those standards, you will have a five-year plan. That is if you can do that in five years. Any program could benefit from a similar procedure.

William Fillmore, Jr.: First, I am going to tell you a little about the structure of my program. I am always searching for a way to make my program better. I began about a year or so ago to deal with structure. At that time, we had center managers whose interests were focused on working in the classroom with children. I felt that there was a difference between managing a center by a nurturer than managing a center by a manager; that is, by someone who could spend a great deal of time thinking about the importance of managing a center. I then clustered my centers, which numbered 13, into six clusters. Two centers were very large, because we were in school buildings. There were over 200 children in each building. That became a cluster in itself. I hired a cluster director and put that cluster director at a site with a secretary. Last year, because of additional funding, I was able to add a curriculum specialist to the cluster. They had to work as a team, one looking at management and one looking at activities in the classroom. That is the first reason that we were ready to tackle the NAEYC accreditation.

Let me tell you what else made me ready. I spoke with my staff about the NAEYC accreditation, because I do not engage in any extra activity unless I get the support of the staff. You cannot be successful in any endeavor unless the staff has bought into it. We talked about whether we were going to start with one, two, or three centers. We decided to do it with all the centers. We went through the self-study and then through the process. Fortunately, nine of my centers at that time were awarded the accreditation. Three did not pass. Two were due to circumstance: we were in a housing project. For the third, we disagreed with the validator. NAEYC allowed us to express our thoughts and the center was re-examined and passed. We now have 13 centers, and all of them have gone through the self-study. Eleven of them have passed and are certified.

In the meantime, in my county we had organized the Success by Six. The United Way got together and brought in business executives to talk about what they could do in the area for children. They chose as their first endeavor Project 2000, which was readiness for school. It was the first time in the history of our area that business executives met with Head Start people. They could not understand why children were not ready for school. Therefore, we had to explain developmentally appropriate practices. In the meantime, I had to teach them about Head Start. They kept saying, "You say you have a good program. How can you prove that? What documentation do you have?"

At that point, I decided that we had to document our program. I asked Honeywell Incorporated to work with my managers and teach us Total Quality Management (TQM). Total Quality Management includes involving the total body in decision-making. It is from the bottom up, not the top down. I had to decide to relinquish some of the decisions to the staff. We made cluster teams and talked about continuous changes that would bring about quality in the program.

We decided as a group to do the Quality Initiative. It was right after we had gotten our NAEYC accreditation, and I felt terrible about asking the staff to consider the NHSA Quality Initiative. With some hesitancy, they all agreed that we would tackle this process. I assigned the education part to the education director and the social services part to the social service director. Much to my surprise, it did not work. You have to utilize everybody when dealing with all of the areas, because they overlap. NHSA does not tell you how to do this. You have to develop your own process, and that is a plus. In doing so, the end result is more effective with your program, whether you receive the award or not, because it strengthens the team. It shows everybody that there is component integration, and it is motivational for the staff.

After being selected as a program of achievement, my staff began to raise money to continue that climb up to the program of excellence. This meant that we had to show the impact of our program in the community. In the meantime, one of the recommendations that had been made to us at the program of achievement level concerned our office. When we did the program of excellence, we moved our offices into a partnership arrangement by developing one-stop shopping for families. We moved in with the Children's Board and Coordinated Child Care—the child care providers, the license board, and Head Start. We are all located in one building. We have developed what we call the PECC, Pinellas Early Childhood Collaborative. What we are doing is streamlining all activities for services to children in our district. We received some funding through the state, and Head Start serves as the fiscal agent.

I would like to encourage Head Start folk to go through that process. There are many significant things we have accomplished by going through it. One is the recognition of being a program of excellence. People that would not talk to us before are talking and asking for assistance. It is a good feeling. I highly encourage it.

Program Evaluation

Audience Questions and Comments

Comment: I am from the High Scope/Head Start Quality Research Center, part of the consortium of four centers. Our task collaboratively is to develop outcome measures of quality nationally across Head Start centers. Specifically for High Scope, which is located in Ypsilanti, MI, we have selected as our research focus the broad area of staff development and training. It appears there is a double-edged sword with respect to staff development and training in Head Start. The more effective you are at elevating your staff training, the larger risk you take in terms of marketability outside of Head Start. If we can just open up that discussion, we would appreciate it.

William Fillmore, Jr.: First, I would like to remind us of the philosophy of Head Start. In that philosophy, it says that we have the responsibility of training people well so that they can move out into the broader field and carry the Head Start concept with them in a positive way.

Gayle Cunningham: Staff training is a big issue in Head Start. We have dealt with it in Birmingham in a number of ways. It took a little while to become positive about the fact that we do so much training and regularly lose staff. Mostly, it has been staff who have been with us for a while and worked on their Bachelor's degrees. After saying they will never leave Head Start, they obtain their degree and get a call from a principal who wants them to come teach kindergarten. We now consider it a contribution to the school system. The personnel director tells me that we are her best training ground for new teachers. We understand that we will never be able to pay Bachelor's degree teachers what they can make in any of the local school systems. We believe that we can offer a quality program with staff who have CDAs and A.A. degrees. Those are the two credentials that we help our staff to obtain. Our career development goal for staff is that all our teacher aides and teacher assistants will have the CDA credential and that all our teachers will have A.A. degrees in child development or early childhood education. What we tell staff is that if they wish to obtain a degree higher than an A.A. degree, we will support them, but we will not pay for it. Then, we do not feel quite as bad when they leave. We give them the same time off and support so that they may obtain their degrees, but we put our money into CDAs and A.A. degrees. We support higher degrees for staff at other levels. We also have family service workers whom we are training and Social Services coordinators for whom we are providing training.

Marco Verzarro-OBrien: It is a dilemma that I also wrestle with because I know that Mr. Fillmore is right. One of the original intents of Head Start was to invest in people and communities by giving people opportunities to grow and develop and then contribute in larger ways to their communities by leaving Head Start. I contrast that with the research that tells me that staff turnover is not an indicator of quality, but rather one of the many things that makes quality even more difficult. In the publication that I mentioned earlier, the turnover rates that are self-reported by programs on the PIRs from 1990 to 1995 are lowering. This confirms the notion that if you invest in human resources and increase salaries and fringe benefits, which was one of the 1990 and 1994 investments that Congress and ACF made in people, you will decrease turnover and improve quality. That is showing to be true in Head Start. The turnover rates are slowly dropping as we raise salaries and add to or add fringe benefits. The bottom line is that you cannot refuse to invest in training people with the attitude of keeping them down on the farm in hopes that they will not leave. The lesser of the two evils is to invest in quality and simultaneously keep trying to

raise salaries and fringe benefits. However, Gayle is right. In most communities, especially communities where public schools are unionized, we could never compete with them in salaries and fringe benefits.

Question: Do any of the current research efforts focus not on outcomes, but on the indicators of high-quality programs?

Marce Verzarro-O'Brien: We realized since we created the initiative that we were going to end up with a pool of programs that could be studied in some systematic ways that would inform this quality discussion. We only have a pool of six right now between the two initiatives. My sense is that after the upcoming year, even if half the programs apply, we will still have a large pool of programs from which to draw. We are looking for funds to do that kind of systematic study that looks at the characteristics that cut across programs.

William Fillmore: I would like to add that in Region IV we looked at peer assessment and talked about those programs that have gone through the assessment in terms of Performance Standards. This is not research, but it is one step in that direction. We are talking about visiting those programs with a federal group and developing best practices in that program. Maybe that would lead to a foundation of research that could be developed.

Gayle Cunningham: The Research Centers on Quality are looking at processes within programs that contribute to quality and will have an opportunity across the four projects that involve at least 12 different programs to do some very close looking at processes. They will be working with us for five years collecting data and observing our work.

Comment: Anyone who is serious about a definition of quality would have to be inclusive of various manifestations of quality. Essentially, that is what we are looking for with the consortium, the four Quality Research Centers. We agree that there is a baseline for indicators of quality and that the incidence of various indicators of quality would move you along the quality continuum.

It is important to respond to something else you had said in terms of outcome. Our focus on outcomes at this time no way supplants certain things that cannot be outcome-based. Rather, it is to provide the National Head Start Association with a different, wider array of measures and information to provide to others. We have to be concerned about policy. We need to make sure that there is documentation for the wonderful things that we all know happen. It is to provide a clearer picture of the fullness and richness of Head Start. Outcomes, in addition to the more qualitative processing aspect, will provide that information.

Sue Bredekamp: The focus now at every level of education is on outcomes, and that is a challenge for us in early childhood education. At some level we have to say what it is we are trying to do, what we are trying to produce as an outcome of good-quality, early childhood education. If you look at the studies that have gotten any attention in our field in the last few years, it has been outcome studies. We can see clear outcome-related pieces of data that have far more of an impact than saying something like we all need more salaries, more training, or better inputs. We have to do a better job of defining outcomes. At the same time, we have to be clear that there is no way that we can ever move in this field to a strictly outcome-based framework, because our outcomes are works in progress. Our children are moving targets and we want them to be. At the

Program Evaluation

same time, we know that our programs are about putting them in a better place when they leave than when they started. We are committed to that. Therefore, those in the field of early childhood have to clearly say what it is they are striving for. What are the goals for children? How will they be measured in ways that are meaningful?

Gayle Cunningham: Sue, I wonder if the data that you have on Head Start programs that have achieved NAEYC accreditation might be useful in looking for commonalities.

Sue Bredekamp: That is a very good idea. We have 4,700 programs that are accredited, and we are at a place where we need to do more research on them. One piece of information that we reported at our tenure point was a study done by Paula Jorde Bloom, who analyzes the organizational climate of a program. She has been evaluating dimensions of organizational climate long enough so that she has a large data pool of programs. She also has a subset of programs in that data pool that are NAEYC accredited. As a result, she was able to do an analysis comparing the two. Frankly, I did not think there would be any differences, because our system does not focus on such dimensions. We do not have standards that do a good job of addressing the organization and the administrative variables that support that. What she found was startling to me. She found that in all 10 dimensions of organizational climate, the sample of accredited programs was significantly better than the sample of nonaccredited programs. Again, they were not a random sample of programs, because those were programs that cared enough about the organizational climate to go through this mechanism. What she found also was that among the 10 variables, there were 4 where the accredited programs were the highest, and they were the ones that related to the TQM kinds of indicators. They related to goal consensus and shared decision-making in which the staff know why they are there and what the mission of the organization is. They participate in shared decision-making. That is a strong predictor of a successful accreditation experience. The variables relating to the team concept were the things that differentiated the programs that had better quality for children from the ones that had not been accredited. There is some data to support some of these process indicators. Linking those to outcomes for children is another piece that we have not done as well and/or as thoroughly and also needs to be done.

Comment: In Head Start and programs for very young children across the country, we have created a lot of our own problems by calling it early childhood education instead of child development, and by not bringing in all of the other disciplines that are so necessary if we are to create the caring, nurturing environment that certainly is going to be necessary as we move to Early Head Start. It may be just from some of the states that I am aware of and then, particularly, my own state, Arkansas, where the colleges and the higher education framework has had to re-look at what goes into education. Some of the colleges are still not considering going down to nursery or prenatal, still thinking that preschool education starts with age four or five. I am hoping that as you work on staff development, you will consider a different mental framework about what goes into staff development and staff training to bring about the skill, the knowledge base, the awareness between parents and staff, and the things that are important in working with younger children, rather than things that may be more appropriate for older children.

In Arkansas we only have 2% staff turnover in Head Start. A lot of it is because we made an effort to increase salaries. We moved toward the Bachelor degree, the associate degree, the CDA, as absolute minimum requirements. We also moved to good fringe benefits, good buildings to work in, and a good atmosphere. However, we are having some difficulty in our state deter-

mining what is appropriate for very young children and what kind of staff training should be in place. We have people that are still doing the same kind of training they did in 1965: the psychologists, the psychiatrists, the counseling group, the nurses, the dieticians, and so forth. I hope that somebody will try to change the mentality of what is involved in child development and education.

William Fillmore, Jr.: There are many different areas that you have covered. However, I would like to respond to one part. In the State of Florida, we looked at early childhood, and we looked at the needs of children. I sat on the Coordinating Council for Early Childhood Services. We agreed that we would begin to call it Early Education and Care Programs for some of the reasons that you have talked about, because our responsibility was for children from zero to eight years of age. We are trying to foster that within the whole State of Florida.

Comment: I have just been part of a wonderful experience working on distance learning in Appalachia with Head Start administrators and teachers, six of whom have just received their Bachelor's from the University of Maryland, Eastern Shore. Unfortunately, there is going to be staff attrition in some of those Head Start programs, because, as was mentioned before, the public schools are offering jobs that have higher salaries. We have to address this issue. With all the energy that we are putting into Head Start and other early childhood programs, something has to be done on a policy level.

Gayle Cunningham: In regard to the issue of attrition, for every story that I can tell you about a staff member who obtained a degree and left us, I can tell you a wonderful story about a parent who became a teacher's aide, and whose life was changed because they obtained employment with us. We have a staff of just over 200 people. One hundred of them are former Head Start parents. For each of them, there is a wonderful success story. Some will never do anything more than be a teacher's aide. That for them is a wonderful achievement, and we work with them on obtaining CDA's and further training. There is a balance there, and there is a balance that exists throughout Head Start of people leaving and people coming in that more money cannot address.

Comment: As we talk about outcomes for children, one thing we should concentrate on is the measurement of outcomes, and being consistent, so that as we make comparisons between our programs and as we try to improve our programs, we are talking about the same thing.

Marce Verzarro-O'Brien: I was going to make a quick comment about the remarks on training. It always has struck me that we have a very odd training mix in early childhood. In some parts of this country, schools of education, both at the A.A. and the B.S. degrees, reign supreme. In other parts of the country, particularly in the South and the Midwest, land grant colleges of home economics or human ecology are supreme. We have a group of people who have been trained in the kind of model that you are talking about, which is bringing many seemingly diverse perspectives to bear on child and family development, which I have found over the years in Head Start is much more relevant for staff than an early childhood degree. I am a product of the former, but have been socialized and taught throughout the latter system of home economics. I would be interested in hearing from Sue about where this training issue fits in terms of NAEYC career development.

Program Evaluation

Sue Bredekamp: This has been an area of work for NAEYC, attempting to support or work toward a more articulated, uniform system of early childhood professional development. One of the strategies has been for us to set guidelines for four-year institutions. We have just recently revised them. They are far more interdisciplinary in the way they are framed. If anything, they are so interdisciplinary that people might be concerned that there is no clear message. We have included a lot about health, social services, and parent relationships. There was that risk. However, the risk is worth taking because we had gone so far in the other direction.

It is interesting, though, that we have promoted a specialized early childhood licensure or certification covering the age range of birth through eight. This has been an area where, of all the things I have tried to work toward in my professional career, I have been most stunned, because we have made some progress. We have seen a major trend in states to move toward a broader based early childhood credential. For example, in Connecticut they collaboratively came up with a beautiful framework for early childhood licensure that was going to assist with articulation from CDA to two-year to four-year degrees, and it is right at the end of its procedures for approval throughout the state. The last gasp of resistance has come strongly from the teachers' union, which is exactly what happened in New York. The teachers' union does not want the specialized certification. They want the broadest based framework to provide the range of options for employment. It has been frustrating for the people in Connecticut, but in other states we have seen some tremendous progress. It goes back to the need to build even more alliances so that people can see what it is we are trying to accomplish. In fact, by going to a birth through eight certificate for early childhood, we are trying to open up the range of options for employment for teachers beyond just kindergarten. That is the only thing you can do with a B.A. in Early Childhood. If people could see the rich array of employment options in early childhood education, they might be more interested in pursuing that as a career.

I am going to close by saying that in early childhood education we have done a better job of setting standards for our performance and our professional practice, and of measuring the outcome of that performance and practice than in any other level of education. I defy higher education to show that they have done anything like what early childhood education has done in setting its standards for performance and in submitting itself to monitoring and professional review—as we have done—and in having data that supports the fact that the standards of quality produce better outcomes for children. We should feel proud of what we have accomplished in measuring program quality in Head Start and early childhood.

■ New Directions for Minority Research in Head Start

Co-Chairs: Ura Jean Oyemade-Bailey, Brenda Jones

Presenters: Kimberley Williams, Mary Lou de Leon Siantz,
Howard Stevenson, Earnestine Brown, Tammy Mann, Brenda Jones

Brenda Jones: The minority scholars came together in the 1970s out of their concern that minority children in Head Start were not being researched in a culturally competent way. They also were concerned about the lack of minority scholars involved in Head Start research. Over the last three decades, we have seen more minority scholars interested in research with these children and more culturally competent research taking place.

There are two unifying constructs that guide the process and content of all presentations in this symposium. One is the importance of an ecological framework when looking at the development of minority children, particularly in regard to cultural issues. The second is that research must inform practice and policy for it to be meaningful to the children and families who are participating.

Kimberley Williams: I will draw some parallels between how we regard the Constitution of the United States and how we regard the guidelines for Developmentally Appropriate Practice. I will then address why much more than lip service must be paid to absolute inclusion of ethnic, racial, and linguistic families and community members in the consensus-building of what constitutes best practice and best learning.

Are the Constitution of the United States of America and Developmentally Appropriate Practice guidelines static, fixed in time? Are they to be followed as written without amendment? We consider the original Constitution a great document, a document that declared rights, roles, and responsibilities for its declared citizenry. However, we know that African Americans, women, and Native Americans were not a part of the equation. The framers of the Constitution simply did not consider these persons as worthy of equal rights. For African Americans, three fifths of a person was deemed an accurate determination of worth. After the protests of abolitionists grew, slave rebellions became more horrific and a Civil War killed tens of thousands, the progeny of the framers created amendments. Amendments to the Constitution, for example, the 13th, 14th, and 15th, the so-called Civil War Amendments, were created and adopted to bestow the right of citizenship and the right to vote on a certain group of citizens, many of whom had ancestral roots in the country going back long before the country was declared the United States of America. The original Constitution framers were exclusionary, and to the credit of the dynamic nature of this document and its re-framers, amendments that incorporated other cultural groups were put into place. Yet we know from history that *Plessy versus Ferguson*, *Brown versus The Board of Education*, and the Voting Rights Acts represent evidence of what happens when incorporation is not guided by true commitment to multiculturalism, a real belief in the value of all people, and a policy for operationalizing this value in actual practice.

Like the framers of the Constitution, the framers of the guidelines for Developmentally Appropriate Practice did not really include all people and communities. Like the Constitution, Developmentally Appropriate Practice (DAP) guidelines described universal rules and proclaimed what would be best for all people. And like the Constitution, recent amendments to DAP guidelines incorporate, in a cursory way, a recognition of cultural groups, but do not go far enough in leading the way to real inclusion and making all people stakeholders. The DAP guidelines support the creation of rigid, strictly defined practices. In some cases, teacher equilibrium and

parental and community concerns are relegated to interesting but nonbinding sidebars. To declare slaves citizens without local, state, and federal supportive operationalization of practices that demonstrate absolute rights and acceptance, is thoughtless at best, and subversive at worse. Likewise, to set forth guidelines for best practice and best learning for all children without including the broad array of input from racial, ethnic, and cultural groups, or those from urban anthropology, human development, and other less traditional child development areas of study, is neglectful. But worse, to declare one way as the way, to fail to advocate at federal, state, and local levels for legitimate inclusion of all stakeholders, and the lack of support for operationalizing the inclusion in meaningful ways, is ultimately detrimental to teachers, family, and children, and, in some cases, the profession. Although the framers note that the DAP guidelines may not represent the view of every practitioner and acknowledge a linear view, that knowledge expands and changes over time, and these guidelines are presented as accurate, factual, reified rules. Culture is treated as a characteristic of individuals, much like general needs or interests. In practice this is manifested as a programmatic add-on, a component of a universalistic program. For example, these guidelines suggest that multicultural and nonsexist experiences, materials, and equipment should be provided for children of all ages. How are multicultural materials to be used? For what purpose? To what end are materials made available? Parents and community members must be legitimate stakeholders in how their children are going to be educated, in how these materials are going to be used. The very nature of the programs, the pedagogical practices, and the epistemological assumptions on which they are based may differ. Difference is not a negative. It provides an opportunity for real learning to take place.

We know everyone is not happy with the DAP guidelines. Research tells us that teachers express different views of development, and researchers have different opinions on such questions as whether stages are universal or whether development is an individual or a socially mediated process. In my day-to-day work, both as a professor of cultural context in child development and as an applied researcher in minority communities, I see the lack of consensus, the outright confusion. Parents in early childhood programs serving African-American, low-income, and working-class communities are concerned. I hear comments such as, "We encourage public speaking in our church and Sunday school, but the preschool teacher says that for my child to memorize a few lines from a great speech and then present it is against DAP." In middle-income, African-American communities, many parents wonder whether their children will be allowed to begin reading in preschool or in the early months of kindergarten. They say DAP does not allow phonics. DAP does not encourage letter recognition. What will happen to my child when he/she gets to first grade?

Many magnet and other "desirable programs" are quite traditional in their pedagogical practices. I see the "angst" of those whose job it is to help early childhood programs prepare to meet NAEYC accreditation guidelines. Often these people are from the community, but may have master's degrees from a child development or human development program that promotes an embeddedness in DAP. I hear their ambivalence as they advise programs. They say you cannot have children working together to create one group product. Individual development and individual interest is what is important. Children must learn reading and number concepts through play. You cannot drill them. You must explain this to your parents. These are not isolated instances. I see this daily. There is a constant ambivalence for many teachers who work in ethnic, racial, and linguistic-minority communities between what they would like to incorporate into their programs, based on community and parental expectations and interpretations of best practice and best learning, and what DAP guidelines and accreditation agencies deem appropriate for all children.

Teachers, parents, and community members must be able to speak openly and influentially about what is best for children. Each group of stakeholders must be recognized as having potentially vital and legitimate knowledge. All stakeholders must be part of the real and legitimate conversation in the determining of any practice that best fits a context situation and community. Teachers must have a forum, both in teacher training and in professional meetings, to speak openly about their differing views. The teacher training must be dialogic, not unidirectional. Each children's program must not be placed in accreditation jeopardy if its practices differ from DAP guidelines, as long as a clear and cogent rationale based on teacher-, community-, and parental-identified best practice is provided. Those who speak for and lobby in the arena of early childhood education must lead the way in operationalizing the how's, why's, and for whom's of supporting culturally relevant practice in classroom, family, and community bridge-building. Rather than be interpreted as static and rigid, these guidelines must be dynamic, actively amended, and representative of the voices of the people and families it ultimately intends to represent.

Mary Lou de Leon Siantz: The culturally diverse ethnic population of the United States is the most rapidly growing segment of the population. This is particularly true of Hispanics, whose numbers are expected to increase at more than three times the rate of the total population in the United States. By the year 2040, Hispanics are projected to represent 24.8% of all preschool children in the United States. In general, the growth of the Hispanic community is about seven times greater than among non-Hispanics, which has ramifications for the Head Start population and the country.

The term Hispanic was officially created by the U.S. Census Bureau and describes persons of Spanish origin or descent. A term preferred by some Hispanics, but not used by the Census Bureau, is Latino, which connotes Latin American rather than Spanish origin. With the exception of Mexican Americans, data on the various Hispanic populations was practically nonexistent prior to 1960. Even for Mexican Americans, nationally representative data was not available until 1970. However, as this population grows, both demographically and politically, available data suitable for national studies has also increased.

Although the differences between Hispanics and other Americans are important, differences among the various Hispanic groups can often be greater than those between Hispanics and non-Hispanic groups. We are not a homogeneous population despite the fact that we share a common language and may belong to the same racial group. Some are U.S. citizens; some are not. Some are recent arrivals to the United States, while others have been in this country for many generations. Many speak Spanish, some are bilingual, others are monolingual in English. Hispanics learn English as rapidly as other immigrants of the same socioeconomic status. In spite of their eagerness to work, a sizable portion of the Hispanic community has lower than average income and higher rates of unemployment and poverty than does the general population. Their limited educational achievement continues to be a major barrier to the advancement of Hispanics in the United States.

The Hispanic Health And Nutrition Examination Survey (HANES) was the first survey that provided some in-depth knowledge about the Hispanic populations. The importance of understanding subgroups was readily apparent there. The primary groups reached through the Hispanic HANES were Mexican Americans, Cuban Americans, and Puerto Ricans. It reinforces the notion that Hispanics are a young population with the average age of the mothers being 24 years for Mexican Americans, 27 for Cuban Americans, 24 for Puerto Ricans. For fathers the average ages were 27 for Mexican Americans, 30 for Cuban Americans, and 27 for Puerto Ricans. The Puerto

Miscellaneous

Rican families in this setting paralleled the experience of African Americans in New York City and were primarily households headed by mothers. The family income is rather low for all three groups, although highest for Cuban Americans. The family size was largest for Mexican Americans.

Sixty-three per cent of Hispanics are Mexican American, 12% are Puerto Rican, and 5% are Cuban. Central and South Americans compose 12%, and 8% are categorized as other. Among Central and South Americans, the largest population groups are Salvadorans, with 565,000, Colombians, with 379,000, Guatemalans, with 269,000, Nicaraguans, with 203,000, Equadorians, with 191,000, and Peruvians with 175,000. We also have 520,000 immigrants from the Dominican Republic in the United States.

Most Mexican Americans trace their racial ancestry to Meso-American Indians and/or Spaniards. Spanish colonizers brought Spanish culture, language, and Catholicism to Mexico when they arrived, and they were here before the Pilgrims landed on Plymouth Rock. Many individuals of Mexican descent have never actually crossed the border into the United States. They have lived for generations on the same land, once a part of Mexico, now part of the United States. This is true in California, Texas, Arizona, New Mexico, Colorado, and parts of Utah. A significant portion of the population considers the southwest United States to be, if not politically, culturally speaking, Mexican.

Puerto Ricans, the second largest Hispanic subgroup, have had a political history that has resulted in U.S. citizen status. Their migration issues have been very different from Mexican Americans. With the U.S. invasion of Puerto Rico during the Spanish-American War, 400 years of Spanish rule was terminated, and the United States retained Puerto Rico as an unincorporated territory and imposed American citizenship on Puerto Ricans. Many Puerto Ricans migrate from the island in search of economic growth, as do Mexican Americans.

A totally different situation brought the Cuban refugees to the United States. They were escaping political upheaval that began in 1959. Before that time, about 30,000 Cubans lived in the United States. In contrast to the Puerto Rican immigration experience, the Cuban subgroup is characterized by a distinct wave of immigration that began with the Cuban Revolution and Fidel Castro. As Castro overtook the government, about 248,000 persons from the professional and upper classes fled from Cuba. After the Cuban missile crisis, an additional 55,000 left in small boats. There have been more recent larger scale immigrations as well.

In terms of immigration, these are three different profiles on three different Hispanic subgroups, having important ramifications. Frequently in the literature, when you see Hispanic as a general term, you do not know who this generalizes to, and that is an important difference to look at. Mexico is by far the main source of both documented and undocumented immigration and accounts for one fourth of the 22.6 million immigrants and over two thirds of the nearly three million formerly undocumented immigrants who have been legally admitted under amnesty. Others have come from other Latin American countries fleeing civil wars.

Understanding the differences that occur among the different groups is important, but so is understanding the different cultural aspects that must be considered when doing research with them. There are several areas that need to be considered. First is collectivism, the importance of the group versus the individual, that researchers have proposed as a basic Hispanic value. Such a value emphasizes the needs, objectives, and points of view of an in-group, while individualistic culture determines social behavior primarily in terms of personal objectives, attitudes, and values, and resembles little of the in-group. Because it is collective, the Hispanic culture differs in many ways from the individualistic, competitive, achievement-oriented majority culture in the United

States. As a result, Hispanics prefer interpersonal relationships in groups that are nurturing, loving, intimate, and respectful. This makes the need for explicitly friendly interactions in a research setting important. Researchers have found that Mexicans, and children in particular, are more sensitive to nonverbal indicators of feeling. Such behavior is referred to as *personalismo* and builds on warm, individualized attention and responsiveness in interpersonal interactions. This behavior is coupled with interpersonal respect. Respect, or *respeto* among Hispanics, dictates appropriate differential behavior towards others on the basis of age, sex, social position, economic status, and position of authority. As a researcher, no matter how young or old, you are in a position of authority and will get respect as a result. Elders expect respect from younger individuals, adults from children, men from women, teachers from students, employers from employees. *Respeto* should not be equated with distance. Researchers, because of their professional role, education, and training are viewed as authority figures.

The second area to be considered is "familism." This is a cultural view that involves individuals' strong identification and attachment to their nuclear and extended families. This is true in all the Hispanic subgroups, whether a Puerto Rican maternal head of household, Mexican with the mother and father present, or Cuban. Familism goes along with collectivism. It emphasizes interdependence over independence, affiliation over confrontation, cooperation over competition. It includes a strong identification with attachment to members of the same family.

Acculturation is another area that needs to be considered, and it requires that an immigrant child integrate the culture of their parents and the mainstream culture. There are a lot of factors that need to be considered when looking at acculturation. One is the language spoken in the home. For Mexican Americans, home language identifies whether they consider themselves Mexicano, Mexican American, or Chicano. Mexicano is someone who is more traditional. In my present study with the migrant Head Start population, some of the cultural variables I have looked at are 1) religion (in this primarily Catholic group); 2) language (they speak mostly Spanish); 3) years in the United States (an average of 19 years for the mothers, 19.55 for the fathers); and 4) acculturation (they consider themselves primarily traditional Mexican). Biculturalism has become another area of consideration, because we need to understand that children have to learn to accept their culture of origin as well as their host culture.

When planning methodology, you need to know the Hispanic subgroups. In terms of translation of measures, how they are translated and who translates them has to be carefully considered. Instruments need to be translated into Spanish, then translated back by an independent person before they are used. Second is context. Michael Rutter pointed out the importance of the environment. While Hispanics live largely in urban communities, I have been working with largely rural communities, children of the road. If you are not part of the culture, you need to identify leaders in the community with whom you can work to give you entry into the community. New models have to be developed to work with new populations. I have adapted much of what Michael talked about in terms of resilience—looking for positive outcomes and within-group variation. There is a lot that is not known about individual subgroups across cultural groups. I cannot reinforce enough the need for within-group studies and within-group variation. Developing research partnerships is highly important. What is in it for the population? Who is going to use the data, and how will the data be used? Training is important for researchers and research assistants. How can the information from the data be used in Head Start settings or for staff to improve their professionalism? What positive outcomes exist not only for the university and the researcher, but for the community?

What we need, given this background of Hispanic and cross-cultural research, is within-group studies. There is little known about fathers, especially where fathers are a major presence, true for most Hispanic subgroups. We need culturally appropriate instrumentation. We need to study the impact of acculturation on parenting, parent/child interactions, parental characteristics such as in self-esteem and mastery, and mental health. Acculturation is a process that is going to impact positive outcomes. We know that first-generation Hispanic subgroups do better in general than do later generations. We need to find out what in the culture should be kept and maintained to support these positive outcomes and what, when the acculturation takes place later on, produces the negative outcomes. We know little about immigrant preschool children and children of immigrants in general. We need to study the importance of social supports to these families, especially among immigrant parents and other cultural groups. We know that it is important, but more longitudinal studies need to be done that not only look at the isolation of parents, but also at how support can facilitate children's growth. Research is also needed on the development of cultural competence. In working in any Head Start setting, cultural competence is going to make or break the success of the study.

Howard Stevenson: I am going to talk about a study that we are working on entitled "Buffer Zone: Racial Socialization Experience and Anger Expression among Black Youth." Racial socialization is the process whereby families talk to their children about race to prepare them for a racially hostile world. There has been early research looking at how mothers of young children engage in, and are concerned about, racial socialization. There are data available with respect to measurement on adolescents and parents. We are interested in the context of how people talk, or not talk, about issues of race with their children. The neighborhood that we are studying is called The Bottom, in a section of Philadelphia that stretches about 10 to 15 blocks and has an identity in and of itself. It is important to understand how people conceptualize what it is like to live and be there.

Our study is part of a research program on adolescents and parents' beliefs and experiences of racial socialization and family coping that has been going on for about four years. Our sample is about 22 parents, most of whom are mothers. We ask questions about racial socialization, and also about living in contexts that are sometimes violent. Other questions have to do with when and where one might engage in racial socialization. Our team is a multicultural group of doctoral students. My background is in family therapy, and I am interested in how we change interviewing to get at difficult topics with respect to people's lives. Race is a difficult thing to talk about. You realize as you begin to ask questions about race that you are, by asking the questions, intervening as much as you are assessing. Intervention and assessment are hard to tease apart.

Cultural competence is an idea, but it has to do with actual behaviors and how people think about the world. We have tried to promote a culturally relevant interview style by appreciating and encouraging African-American style and expression. In the interview we look for ways to encourage people to talk in a way that they feel comfortable. We are interested in people talking to us in the way that they might talk around the dinner table. It coincides with an African proverb that says, "The lion's story will never be known as long as the hunter is the one to tell it." To get people to tell their story in the way they are used to telling their story, it is important to promote the use of African-American English. We also think of our interviewers as being real people—spontaneous, flexible, funny, and willing to cry. The stories that people tell are mixed with a lot of sadness and triumph. How you respond to that goes against the grain of how we have been taught to engage in structured research. Our interview style is semistructured to look for open

expression and how emotions are triggered by stories. When you ask people about race, you realize that they learn to talk by hiding their true feelings about race, racism, cultural pride, and the like. However, as they are telling their story, emotions are triggered that then trigger memories about events that have been blocked.

All of the sessions are videotaped and should show cultural expressions and communication similar to what has been reported in the literature. There is a mass of diversity in African-American behavior even in The Bottom section, where our study takes place. There are people who have been making lists of African-American cultural expressions, and our coding system will continually be revised to include these aspects, ranging from affect, harmony, orality, the notion of distrust, styling, and the use of language around oppression and paranoia.

"Buffer Zone" also has to do with finding a safe place or being in a safe place. Some of the assumptions we had in doing this research involve what it means to be living in The Bottom. Initially, we heard, "I may be from The Bottom, but I haven't bottomed out. I just want you to know that." In many respects, they are concerned with what we think of them. One of the reasons for getting to the place where we can have a dinner table conversation is to get beyond the impact that the image has on both self-perceptions and the conversation. People feel violently oppressed by the image others have of them. They talk about it consistently. We have to disassociate ourselves from those perceptions. This image ignores the strengths and the stress that people, particularly mothers, have been dealing with on a daily basis. The image affects social services, and people wonder if Head Start staff interviewing them are also judging them by where they live.

People talk about their experiences in a culturally and contextually meaningful way. The racial socialization that we did hear about was filtered through this life context. As we began to ask questions about racial socialization, we realized there were many other questions that needed to be asked. People are eager to talk, but one of the reasons they want to talk is that they have been isolated. When someone asks them a question in a way that makes them feel trustful, they share a lot about themselves. When their language changes, a different dialogue begins—an indicator that we are about to get valuable information and not necessarily what others think are good data.

Racial socialization by parents is often triggered by a child's questions. He or she will ask, "Mommy, how come I'm so light?" That makes families think about whether they should talk about this more. There are some parents who do not even talk about experiencing racism. At first that shocked us because we expected to find everyone in the neighborhood talking about it. Some people just have not been outside their neighborhood. Those who do experience racism tend to support racial socialization with children more. Having contact in predominantly White working contexts may be a deciding factor in exposure to racism. If you have been in the neighborhood all your life and you have not experienced racism personally, you are not going to find racial socialization an important issue. If people were not talking about racism, then colorism was a major issue. Children have to deal with other African-American children on the block around the issue of lighter or darker skin. This still constitutes an area of racial socialization that many of us are struggling with in our measurement and our intervention.

Asking questions about race and culture cause reactions that make people think. How they avoid talking about these issues becomes interesting. There is a lot of submerged suffering, and people hide ugly feelings about experiences of racism in order to cope. It is not out there in the open as some might think. If you thought about it every day, you might lose your mind. Future research has to evaluate whether the integration of racial socialization—anger that often comes from thinking about life in context—is meaningful for all children. It happens by omission and

Miscellaneous

commission. There are those who are talking about race when they think they are talking about something else. We cannot always get at these nonverbal and indirect means of racial socialization.

There are questions of whether racial socialization influences competence and survival. Should we be talking about skin color issues with children at this age since they are beginning developmentally to understand issues of difference regarding color? Research strategies have to appreciate life realities. Parents who live in stressful contexts raise their children with that in mind. They keep their children inside the house if they feel the neighborhood is dangerous. That constitutes a different style of parenting than for those parents who feel their neighborhood is safe. Some liabilities are assets, and some assets can be liabilities. Strengths can erode over time. Both research and intervention have to be driven by and for participants. Both resistance to our help and cooperation with it constitute a strength, and that must be something that we also include.

Cultural expression must be appreciated in research strategies and in the selection of variables. Being African American is more than a biological phenomenon. Race matters, but culture matters even more, and so does style. Research has to understand how people feel as well as think. I leave you with two questions. First, to what degree are people telling us intimately what is really going on for them, so that we can make effective evaluations of their competence as well as where they are hurting? Second, how does measuring cultural expression allow for the identification and expression of unique strengths?

Eunestine Brown: I am going to focus on strengths in African-American families. We can talk about strengths, not romanticizing about the challenges, but focusing on understanding strength and variation within families.

We know that children in families in poverty face uncertain conditions and countless obstacles. We have moved in the literature and in our understanding to realize that these children are not all the same, they are not homogeneous. In addition, we cannot compare them to middle-class children. When we do that, we miss information about changing demographics, diversity, and their strengths and challenges.

There are five challenges that are mentioned in *Beyond the Blueprint* from the National Academy of Science. They are also challenges for Head Start: 1) to understand the increasing ethnic and linguistic diversity of families; 2) to understand how violence and resource-depleted environments affect our families; 3) to understand the changing economic landscape; 4) to recognize that African-American families are not homogenous; and 5) to focus on what is right in African-American families. When we talk about children and families in poverty, we know that the picture is even more bleak for families of color, particularly African-American families in poverty. Historically, African-American families have been very vulnerable to stress, especially economic stress. I was glad to hear Tony Earls bring up oppression and racism. In our research, we try to sidestep those issues, but we know that they are real issues. The media tends to focus on the severity of the crisis. We always hear about what is wrong, but we never hear about what is right. If nothing were going right, then we would not have any African Americans in this audience. I would not be standing here. We would not have happy, healthy African-American children.

If we look at some of the historical literature and the research that has been conducted by African-American scholars, we find that they have identified five assets in the African-American family. These are 1) a strong achievement orientation; 2) a strong work orientation; 3) flexible

family roles; 4) strong kinship bonds; and 5) a strong religious orientation. These were put forth by Robert Hill in 1972 in *Strengths In Black Families*. I have been looking at these assets in contemporary African-American families, identifying and documenting them, helping families strengthen them, and helping other families who may not be using them to understand that these assets are alive in their own environment.

My data is part of the National Head Start/Public School Early Childhood Transition Study. This is the congressionally mandated study across 31 sites in the United States, including Alaska. The study is on over 8,000 former Head Start children who are now in kindergarten, with two cohorts of over 4,000 children each. I am going to focus on Cohort I. In the Transition Project we look at DAP, health, parent involvement, and social services. There are nine national study questions. The one I focused on looks at family variations, resilience, and adaptability. In Cohort I, 47% of the sample are White, non-Hispanic, but the next largest percentage are African-American families. I am focusing on the African-American families for this discussion. This sample consists of 982 families. The mean age of the children is 5.7 years. Half are male and half are female.

The instruments we used were the Family Background Interview, which taps child and family demographics, and Getting to Know Your Family, an open-ended interview that asks families about their strengths, goals, and problems. We want families to tell us their own stories. It is not often that we ask families, especially poor families, to talk about their strengths. We start the interview by focusing on family strengths, asking for positive qualities about the family.

Here are some characteristics of the families. They are 95% African American; 99% speak English; 46% have a child who was in Head Start or is now in Head Start; and 66% have help with caregiving either from grandmothers or from the father. Only 4% of the caregivers say they have a problem that interferes with providing care for their child. Quite a few of the families continue to receive services, such as parent education. This is an impoverished sample with close to 67% making less than \$800 a month. We also ask about whether income has changed over the years. We want to look at persistent poverty. Families who are in persistent poverty situations have different conditions, different challenges. The majority of families are still receiving AFDC and food stamps. Many of the children live in public housing, but a large proportion of the families live in houses or apartments. Eight-two percent of the children live in single-parent households, or with one other person, the father, or another relative. Twenty-eight percent of the children have four or more siblings, and 56% have three or more. We looked at correlates to family stability, such as how long they stay in one place. Fifty-three percent are in their homes for less than three years. Twenty-three percent are in the same apartment, or same home, for less than one year. Of those families that have moved within the last year, 28% have made two or more moves. In terms of the educational background of caregivers of former Head Start African-American children, close to 60% have less than or equal to a high school education.

The second instrument, Getting to Know Your Family, looks at four dimensions: 1) family strengths; 2) hopes and goals; 3) needs for improvement; and 4) problems. We ask, "When you think about your current family, what are the special strengths and positive qualities that you like in your family?" The parents are able to give up to five responses. Another question is: "Your child is now in kindergarten; as you think about this new period in your child's life, what are some of your hopes and goals for your child?" When we talk about improvements, in almost all families, there are some things that people would like to see improve or change. Other questions are: "What goals do you have for your family? What are some of the problems that may interfere

Miscellaneous

with your child's adjustment to school?" We were careful to pay attention to the specific cultural contexts of the families.

Families reported their strengths to be their values, beliefs, religion, culture, strong and flexible communication, stability and structure, and positive relationships and activities. Thirty-one percent talked about religion or faith in God as being a family strength. In relationships, they talked about being supportive, cooperative, helping one another, and togetherness. Head Start families are eager to talk about what is happening in their families. Families in poverty are resilient. They demonstrate remarkable strengths, courage, and adaptability as they struggle to provide for their children in an ever-changing environment. We need to highlight how families are struggling and adapting to those challenges.

Tammy Mann: I am going to talk about the idea of strengths in a different light. My sample is not a Head Start sample. The study I would like to talk about looks at the transition to fatherhood among African-American men. Just as fathers who live in poverty have been overly studied from a deficit orientation, the same is true of fathers in general. We do not have a good knowledge base of what parenting looks like from a normal perspective. When families are not faced with challenges, what do we expect to see? If we do not have a solid foundation from which to talk about normalcy, how can we talk about something that is not right? I want to share those data. Given our involvement in the Early Head Start initiative, we are asked many questions about how to get fathers involved. The literature does not provide the foundation for developing a strategic or systematic approach. We are doing things that offer a more positive approach.

There have been some advances in our understanding about the critical roles that fathers play in the lives of their children. The nature and quality of their interactions tend to differ from those of mothers. Different does not mean deficient. Fathers should be respected for what they bring to this experience so that they will have an opportunity to play a larger role in the socialization of their children. Fathers are more physically involved with their children than mothers. Infants, when they want that kind of stimulation, know who they can get it from. They are able to differentiate between the roles that fathers and mothers play in the early years of their lives. Despite some of the data in the '70s that suggested fathers showed clinical signs of depression and a number of other negative symptoms as a result of their new experience as parents, fathers tended to adapt well to their role. Looking at the data on the transition to fatherhood during the last 25 years, African-American, middle-class men have largely been excluded in a number of studies that form the basis from which we understand the transition process. That is not to say they have not been included, but when the percentage of the sample is so small, it precludes the opportunity to understand what that process looks like in and of itself, separate from a comparative analysis.

Much of what we know about predictors of father involvement comes from the literature on mother/child relationships, and from there we speculate about what this might mean for fathers. In childhood experiences, for example, much of the work in this area has focused on maternal attachment relationships and their impact on later behavior. From a study done in 1992, we find that fathers with insecure attachment experiences were less likely to display warmth in their own interactions with their children. Those parents who had a positive overall sense of self-esteem were more adaptable in their role as parents. There has been some literature that suggests that fathers who embrace an androgynous sex role orientation, which simply means that they endorse items that are both strongly feminine as well as masculine, are more active in the parenting process than fathers who endorse more traditional sex roles. Fathers who feel strongly about the

important role that they play in the lives of their children are more likely to demonstrate a lot of activity in their new role. There has been considerable support in the literature to suggest that for fathers the paternal role is more interdependent on the quality of the couple relationship than for mothers. When the relationship does not seem to be going as well, this has a negative impact on their own developing relationship with the child. Mothers are more able to separate the spousal role from the parenting role. In looking at infant characteristics, much of the data have focused on the mother/child relationship. To the extent that there is a good match between the infant's temperament and the parent's temperament, you find that the relationship goes more smoothly than when that is absent. There have been few studies that have looked at the impact of temperament on the developing relationship between the father and the child. Finally, in terms of employment status, fathers view their role as that of a provider. Despite our desire to move towards men sharing equally in the caregiving responsibilities of their children, men have not totally stepped away from the importance of providing economically for their families. Vonnie McLoyd talked about this in a study in 1990 that looked at the impact of job loss on parental functioning. Fathers experiencing job or income loss were more depressed, anxious, likely to abuse substances, and had a higher rate for neurosis, psychosis, and suicide. That is in addition to having some negative impact on the developing relationship between the parent and the child.

Most of the parents in my sample were in their late twenties, with at least 15 years of school. It was a middle-class sample. There were 49 fathers, most of whom were employed. The ones not employed indicated that this was not by choice; they were seeking employment at the time this data were collected. This was a pre-posttest design where data was collected in the third trimester of the pregnancy, with a follow-up three months after the birth of the child. The employment status of the mothers did change after birth; employment increased, with more of them going into the workforce on a full-time basis as a result of the birth of their child. That to some extent may speak to the flexibility that seems to be a positive factor in African-American families. There is a lot of role-sharing. In terms of the couple characteristics, most of them were married. Those who were not married were living together and had been living together for two years. There was a bit of discrepancy between mothers and fathers as to whether the pregnancy was planned. There was an even split between male and female babies. Most of them were 39 weeks at delivery; all had birth weights of about seven pounds. Forty-two percent of the mothers reported that they expressed milk to allow fathers to participate in feedings. The age at the posttest evaluation was roughly 14 weeks.

The following is a description of the independent and dependent variables and related findings. The early-childhood-relationship independent variable tried to get at what fathers thought about their own experiences with their parents. Most of them reported that they had accepting experiences. Self-esteem was extremely high for all participants. In fact, because of the restricted range, this variable was not used in subsequent analyses because it did not differentiate levels of father involvement. Paternal attitude was very high. This was a kind of Likert scale that asked fathers to rate their responses on 15 items that spoke to the importance of their role. We had fathers feeling strongly about the important role that men play in the lives of their children. In terms of the couple relationship, there was no difference between pretest and posttest scores on a diadic adjustment scale. Partners were generally satisfied with the quality of their couple relationship. The overall stress index that comes from the Parenting Stress Index (PSI) was low, suggesting that respondents experience little stress. However, fathers did report significantly higher levels of stress regarding their sense of competence with male infants compared to female infants. Regarding infant characteristics, they described their infants as active. They also noted a high fre-

Miscellaneous

quency of smiling and reported general instances of success when they were trying to soothe infants when they were distressed.

In terms of the dependent variable, father participation, we have fathers reporting an equal division of labor with respect to performing household tasks. Mothers did play a greater role in child care responsibilities. They were the ones who had taken the lead even though fathers expressed a desire to move more towards a true 50/50 experience. Fathers were more active in making the decisions that impacted the entire family. In terms of father participation in child care tasks, sex role orientation did account for some of the variance. Those fathers who endorsed a sex role orientation that was more feminine tended to be more likely to participate in such activities. This was different from what the literature suggested about other men, most of whom were Caucasian and middle class. Parental attitude also accounted for 35% of the variance. Those fathers who felt strongly about their role were more likely to participate or support their partners in these tasks. When mothers had their babies earlier than was anticipated, fathers helped out more than when mothers delivered closer to term. In participation in family decisions, parental attitude also shows up as accounting for a large percentage of the variance. Parental stress, which did not show up in father involvement and child care tasks, did show up in their involvement with family decisions. Those fathers who reported higher levels of stress were less likely to be involved in this way.

This kind of work needs to become more prevalent as we are trying to develop programs that highlight strengths, that point to when things are going well, in order to aid our understanding. We do not have that knowledge right now. We need to generate more data on minority families that is based on a normal perspective rather than a deviant one. These findings provide positive information that can be helpful to parent involvement in Early Head Start efforts.

Brenda Jones: I am reporting on a study on children who were prenatally exposed to cocaine and other drugs. Even though we now know that cocaine use is decreasing in the general population, it still remains a significant problem among poor, minority women in inner cities. Much of the previous research looked at the main biological effect on these children, without much emphasis on what the environment contributed to the variability and the developmental sequelae of these children. I was concerned about minority children being labeled as crack babies and crack children, and when they would enter school at age five, the whole system would crash because nobody would know how to handle them.

This is a major problem in our society. About 20% of newborns are affected by prenatal drug exposure, and about 300,000 infants annually are born to crack cocaine-using women. Only 10,000 infants are born to opiate-using women. If we were talking about this a generation ago, it probably would have been the opposite, when heroin was the drug of choice. Cocaine-using women do not just use cocaine; they smoke, use alcohol and other drugs as well. What concerns me most is the number of children who are reared by parents who have some kind of substance addiction. We have to be concerned about what this means for children learning how to trust the world, how to feel confident, and how to be supported in exploring their environment.

We are concerned about the infant's environment from the moment of conception. We have several prenatal factors that impinge upon their development as fetuses, such as the other drugs that the mothers use, the fact that these mothers do not eat, and the fact that they engage in high-risk practices to maintain their drug habit, such as sexual promiscuity. The baby's environment is compromised from the beginning. First, they have the mother's genes. These mothers have significant mental health problems, particularly depression, that we must be concerned about. There is

extensive literature about the effects of depression on infant development in the cognitive and socioemotional domains. In addition, there is the mother's lifestyle: the issues of prostitution and homelessness. Interestingly enough, the mothers who are the most affected by their drug use generally do not have an opportunity to have an effect on their children because the children are either abandoned or taken away soon after birth. The mothers of these children are women who tend to go off for a while and then come back; they stop using drugs and then begin using them again. In fact, some of the research that is surfacing about mothers in treatment shows that they are not abstaining while they are in treatment. Most of them are still actively using the drug. So we have to think about the impact of the mother's lifestyle on these children. Another area to focus on is the other people in the lives of these children. I looked at 120 children who were prenatally drug-exposed and who had come through Children's Hospital here in Washington, D.C. Many of these children were being cared for by many different people, particularly maternal grandmothers, some who were caring for two and three infants and older children of their own children who were drug users.

This study looked at environments, and I did not compare prenatally drug-exposed children to non-drug exposed children. I looked at children who had positive toxicologies on their medical records during cocaine screenings and who were living in one of three environments: 1) with their biological parents; 2) with foster families; and 3) in congregate care, which was done in Washington for about five years, and thankfully they have now closed down a lot of those homes. There was a lot of variability in the homes. Some had only 4 babies, and we have a good reputable institution in Washington that was caring for 70 children. There were six babies in a room with one caretaker. That kind of ratio is questionable.

Here are some of my findings. First, I looked at children who were from 9 to 36 months, which I now know was a mistake because there is too much variability in that age range. I had an unanticipated age confound. The group care children were discharged sooner than I thought because by then the system had realized the error in group care. They were rushing to get them out by age two. As a result, I did not have many children in the over-two-year cell. When I divided the children by age, I found that they seemed to start going down when we started to do language tests. The Bailey test begins to use language items at around 18 to 24 months. There was a consistent decrease in the children's performance over time, which has considerable implications for intervention. In Early Head Start, one of the things to think about is what that developmental shift means for children and what kind of supports we can bring to foster their development in more appropriate ways during that crucial period.

The next thing I did was look at the three groups of children on these outcomes. The variables "emotional regulation" and "motor quality" are from the new Bailey instrument. It has a new behavioral record, and I used that as an observational assessment of the child while giving the child a test. Emotion regulation looks at the child's ability to contain impulses, not to get upset when things are taken away, and so forth. Clearly, the group care children did worse than the children in biological and foster family care. Motor quality looks at whether the child is hyperactive or frenetic in his or her movements. It measures the quality of their movements more than motor skills, *per se*. Group care children did worse than the other children on this variable as well. An interesting finding was seen with behavior problems. Caregivers reported that the group care children had fewer behavioral problems. This was on the Achenbach CBCL, a caregiver report. This was not my hypotheses, but as I thought about it and talked to the caregivers afterwards, what I discovered was that these women had been trained to expect problems in children

Miscellaneous

and often they ignored or seemed to be unaware of the children's problems. That is an adaptive strategy when you have six babies you have to attend to at one time.

I looked at the biological families and compared them to foster families. In terms of age, the biological mothers were much younger than the foster mothers. They had their children much earlier; they were less likely to be married. They were less likely to have graduated from high school and less likely to be employed. They also were poorer than the foster mothers. However, the foster parents had more children in their homes than the biological parents. I also looked at them on a number of psychological variables, using the Parenting Stress Index (Abidin). The biological mothers reported more stress. They were more depressed. They had fewer resources, less family support, more family conflict, and less family cohesion. Basically, the biological families looked much worse on all the variables than did the foster families.

I want to talk about some of the implications of my findings for Head Start. Some of these are based on my own findings and some are based on the work that other people have done. First, Head Start teachers should not assume that because children are developmentally delayed or display behavior problems that these are crack children. In fact, we know that one cannot tell which children are crack exposed and which are not. Second, the Social Service, Parent Involvement, and Mental Health Components need to be more concerned about this issue. We had an intervention where we were finding out six months down the line that half of our sample were using drugs, and the Social Services/Parent Involvement Coordinators never knew that these parents had this problem. Third, there should be collaboration with other agencies. Head Start alone cannot meet the needs of all these families, but there are other agencies that would work with Head Start to provide services. Fourth, the classroom environment should be supported to facilitate the development of all high-risk children. Fifth, interventions should be guided by the features of minority families. One of the things that my research tells me is that the foster families and the biological families, when I looked at child outcomes, were not that different. One of the things that I thought about was the fact that in these biological families there was always an extended family member who was helping to care for the child, or else the foster care agency would have taken them. It was a grandmother or an aunt. They are important supports in these families, and we should not only study them more and think about what stresses they are under, but also give them more support. Finally, we need to access the community. One of the things that we are doing in the program that I am working with is using the church. Many panelists talked about the importance of a religious orientation. We have had churches provide spaces for Narcotics Anonymous groups, provide mentors for these families, and so forth.

■ Recent Foundation Initiatives to Improve the Lives of Young Children and Their Families

Chair/Discussant: Lonnie Sherrod

Presenters: Marjorie A. Gutman, Deanna Gomby

Lonnie Sherrod: Philanthropy as we know it originated as a partnership between social intervention and research. There has been substantial growth in private funding across the century, particularly in the last two or three decades. The growth has been not only in the number of foundations, but in their size and type. For example, since 1950 the number of foundations in the United States has doubled, and the assets of these foundations has doubled even after considering inflation. The largest decade of growth was in the 1980s, with a 28% increase in private funding. Since the 1960s, foundations have been required by federal law to pay out 5% of their assets. Therefore, as foundations have grown, so has their potential impact. There are now, for example, over 300 foundations that are explicitly and directly concerned with children, youth, and families.

The types of foundations have also become increasingly diverse. Foundations such as Carnegie, Ford, and Rockefeller have become independent of their founding family or corporation. There are foundations that have not yet achieved that independence and still fall immediately under the daily supervision of the donor family members or the corporate sponsor. More recently there have been a number of community foundations that have arisen, and their purpose is explicitly to serve the needs of the community in which they reside. Predictions are that this local form of foundations will probably represent the greatest growth in the next decade or so.

The purpose of this symposium is to describe some of the roles that private funding may play in improving the lives of children in the context of substantial federal support for programs for children, and in the context of highly successful federally funded programs such as Head Start.

Marjorie Gutman: The Robert Wood Johnson Foundation, which is located in Princeton, NJ, is the third largest foundation in the United States. It has been in existence about 23 years. The mission of the foundation is to improve the health and health care of the American people. This is rather unusual. Most foundations you may have heard of have several areas in which they work, such as culture, education, and international. We only work in health and health care, and domestically. Within that broad mission, we have four goals. They are 1) to assure access to basic health care for all Americans; 2) to contain costs; 3) to improve service systems for people with chronic conditions; and 4) to reduce the harm caused by substance abuse, including tobacco, alcohol, and illegal drugs. We have had these goals for about five years, and we plan to keep them for at least another five years.

The overall strategy that the foundation uses to pursue these goals is to stimulate, nurture, and disseminate new information and new ways of improving health care, particularly the delivery, financing, and organization of health care. A foundation like the Robert Wood Johnson Foundation is, in essence, a kind of learning organization. Our role is to provide new ideas, stimulate and nurture these new ideas, assess and evaluate them, and conduct related research on new ways to improve health and health care. That implies that we do not fund ongoing services. Generally speaking, we do not fund clinical research. Instead, we focus on new services, model development, model testing of new services and delivery mechanisms, and research that tends to be applied.

Miscellaneous

We use quite an array of specific strategies. The first is service demonstrations, which are usually multisite and what we call our national programs. Free To Grow is one example. That is a hallmark of the Robert Wood Johnson Foundation. Other strategies, which have become increasingly important over the years, include program evaluation, policy, and research training. We also had a communications unit, which focused on helping programs communicate their ideas, messages, and models, and helped the foundation with their communications. In more recent years, we have started to use and fund communications as a direct intervention. A good example of that is in the field of tobacco. We have just funded a tobacco-free children's center, which will be a national resource for media campaigns to reduce tobacco use among youth.

The Free To Grow program is one of our initiatives focused on young children, their families, and neighborhoods. This initiative was developed in 1993. The grants were made in 1994. We are now about two years into the five-year initiative. The goal of the program is, in partnership, to assist Head Start in developing new ways to address substance abuse among the children and families it serves. We have done programs that were partnerships in the most literal sense of the word, that were actually co-funded by a federal agency. This program is not of that nature. The dollars used are not in partnership with the Head Start Bureau, but in every other respect there is a strong partnership.

Let me describe some of the specifics of the program. There are five sites. Each site is a Head Start grantee or delegate agency. The total dollar amount from the foundation is about \$5.4 million, divided among the sites and for technical assistance. The program is structured in phases. Phase I, which has just ended, was two years of development and testing. Each site proposed a model for a new way to address substance abuse for Head Start that they would develop, pilot test, and then implement in their Head Start agency.

The second phase is expanded implementation of the models. Usually, in Phase I each site served one neighborhood from among their catchment area. In Phase II, they are expanding their model to two, three, or four neighborhoods within their catchment area. Our programs are usually considerably larger than this. To do this kind of seeding and development work, it is better to have more sites than fewer. Usually our programs have 12, 15, or 20 sites. However, this was such foreign territory, working with Head Start and in early childhood, that we decided to try it on a small scale, and we are hoping perhaps to expand it to more Head Start grantees.

Here are some of the major characteristics of the Free To Grow program. The first characteristic is that it is a model development program, in contrast to a model testing program. Often service demonstrations are model testing. In other words, local people in San Francisco, Dallas, or New York City have developed a model, an innovative way to address a health care problem. The Robert Wood Johnson Foundation will see if that model can be done on a larger scale in multiple sites and with testing of outcomes and implementation.

This, instead, is a model development program. That entails spending a lot of time talking to Head Start, the Bureau, the regional offices, and visiting sites when we were developing this program. The first thing we found, of course, was that there was a big interest in substance abuse, and there was a receptivity on the part of Head Start. People felt there was a need to work on substance abuse. The second thing we discovered was that Head Start had already begun to work on substance abuse. There was a technical assistance initiative done by the Bureau and various individual Head Start grantees working on the program. However, we did not find that there was a model that seemed to warrant a large-scale, multisite demonstration. Also, Head Start is such a diverse program that it is unlikely that one model will fit all sites. Instead, we decided to launch a model development program, to give some Head Start grantees or delegate agencies an opportu-

nity to implement local, homegrown, innovative ideas about new ways that they could work on substance abuse.

We decided that there were a few guidelines for the grantees. The first was that each of the models could be different, but they all had to focus on one or two goals: strengthening families and/or neighborhoods. In other words, we decided on a broad view of prevention. The focus for the young children would be on strengthening their immediate environment, with the idea that this would, over time, reduce their later vulnerability to substance abuse and probably to some other risky behaviors and adolescent problems. It is a long-range prevention strategy. In addition, we decided on a conceptual framework for the models. They could all be different, but they all needed to employ the framework of risk factors, protective factors, and processes that come from the mental health area, as well as the substance-abuse literature. The last parameter we gave the sites was that, in developing their model, each had to have an active, strong partnership with one or more community agencies that were targeted to the model they were developing; that is, they all have other collaborators, but they had to have at least one partnership. Usually, the partner is an organization with expertise on substance abuse that would complement the Head Start's expertise.

At this point, I would like to share a couple of examples of the Free To Grow models. The first one is *Aspira de Puerto Rico*, which they call the *Compi* model. It is an intensive family-to-family mentoring, culturally based model. *Compi* is a central and important concept in Latino culture, similar to our concept in Anglo-Saxon or American culture of godparent. In Latino culture, it is a strong, important figure in the family. They use that as the basis for developing the family-to-family mentoring process. The first component is the *Compi* families, who meet at least weekly and interact with the participant families to provide support, advocacy, and modeling. The *Compi* families are Head Start families who are further along in family functioning and have a lot to offer the other families. The participant families are families with severe problems, who are in need of the help. I want to emphasize that both sets of families are carefully and rigorously selected by *Aspira*, and the *Compi* families receive extensive amounts of training, support, and supervision, embedded in the rest of the Head Start program. Using the *Compi* family-to-family mentoring system as a base, they extended their model to neighborhood mobilization. Once the participant families have worked together for about a year (i.e., after the *Compi* intervention ends), they become part of a family support network to continue the support, the learning, and the resource utilization. Finally, a community steering committee is set up, made up of both families and local government agencies.

The second model is quite different. It is *Drew University Head Start* in Compton, CA, near Los Angeles. Their model is applying civic organizing to linking Head Start and schools. Civic organizing is a particular way of addressing neighborhood organizing or mobilization. Head Start is at the center, around which is the neighborhood with its elementary schools. Residents are mobilized to improve the neighborhood and to particularly focus on issues of substance abuse. Drug dealing and alcohol, with many alcohol outlets and billboards, are prevalent in the neighborhood and around the schools. The three components of their model are Head Start, the elementary school, and the community action coalition. For that neighborhood, the community action coalition is composed of 1) parent advocates who are trained and receive stipends for a period of time to work on neighborhood organizing and 2) youth advocates who are used more and more in neighborhood mobilization.

I want to share some of the lessons we have learned from the first two years of *Free To Grow*. First, in terms of process lessons, we found that there can be a real complementarity

Miscellaneous

between Head Start and a foundation. Each organization brings some important strengths to this effort. Head Start brings an intimate knowledge of, and connection with, the families and the neighborhoods. We were interested in focusing on low-income families and neighborhoods where substance abuse is an issue, and often has greater consequences for the children than in other neighborhoods. Also, Head Start has a huge national infrastructure. There are many opportunities for finding grantees who can do this kind of work, and then disseminate and replicate when the models have been developed. The foundation brings more specialized expertise on health care and substance abuse and a 20-year experience with model development, service demonstrations, and technical assistance. Another process lesson we have learned is that for this kind of a national demonstration, it is important to work with Head Start at all levels. We have had interactions at the national level—the Bureau and the National Head Start Association—regional offices, and, of course, the local Head Start sites themselves.

In terms of lessons pertaining to the program side, I would like to point out four things. First, there are some promising models that are still being developed and are going to be implemented more widely. Second, we have confirmed the hypothesis that Head Start or, in fact, any agency, cannot go it alone when it comes to substance abuse. It needs partnerships. As an example of one of the kinds of partnerships that can develop, one of the sites in Colorado Springs, CO, had one of their main partnerships with a substance-abuse treatment organization. The treatment organization had a designated counselor for Head Start families who was paid by Free To Grow for the first two years. You probably are wondering what happened when the grant money ran out. What happened was that the State of Colorado freed up some new monies for treatment, actually a new way of using Medicaid. The counselor dedicated to working for Head Start families will remain. In fact, the agency is considering adding two or three more counselors. In this case, an intensive partnership developed. A third lesson is that neighborhood strengthening or mobilization is expanded territory for Head Start. We understand that the roots of Head Start were in the community in the "war on poverty," but as Head Start has evolved and as it exists in 1996, it does not automatically do community or neighborhood mobilization. However, these sites have been working on that, and it is not easy, but they have made wonderful headway. What is crucial is whom they hire and receiving a lot of technical assistance. Finally, intensive family intervention can be used as a stepping stone to neighborhood mobilization as well as an end in itself. You will notice particularly with the Aspira site that they started with intensive family strengthening, and now they are using that as a springboard for neighborhood mobilization. That has been an interesting concept for us to consider.

Deanna Gomby: The David and Lucille Packard Foundation is a family foundation. I want to talk about the efforts that the foundation has made in funding research and evaluation in the past few years and show how this evolved and how a family foundation operates. The Packard Foundation was established in the mid-1960s by David Packard and his wife, Lucille. David Packard was the cofounder of the Hewlett-Packard Company. All that we do is a reflection of the interests of the family. Mr. and Mrs. Packard are no longer on the scene, but their four children, who are now adults, are life members of the board.

Grants this year will reach \$120 million. Of the \$120 million, \$20 or \$30 million are related to children and families. Probably about \$7 million of that are earmarked for children under the age of five or six. Of that, probably a million or two may be related to research and evaluation. The assets of the foundation are likely to grow. With Mr. Packard's recent death, it is likely that instead of having \$120 million, we will have \$300 or \$350 million a year. The board is

undertaking an in-depth planning process to figure out how this will be handled and which areas they want to emphasize.

I will talk about how the Center for the Future of Children started, because that will give you an idea of how our foundation operates and how family foundations typically operate. Mrs. Packard was the heart and soul of this foundation until her death in 1987. She was on the board of many local nonprofit agencies, had a long-standing interest in children and families, and went on site visits to grantees. She acted like staff for our foundation. When she died, Mr. Packard wanted to do something that would be a tribute to her and/or at least a continuation of her interest in young children. Thus, he established the Center. It is a part of the foundation. It has a multidisciplinary staff, and we split our time between grant-making, in-house research and policy work, and publishing a journal. The other thing to think about is how personalities can shape things. Mr. Packard was an engineer by training, so he understood the importance of applied research with implications for policy or practice.

Let me be more specific about our activities. I am going to give two examples of grants, and then talk about the journal. These are examples of things that connect grants, research, policy, and practice. In the child development area, grants this year will probably total about \$1.8, \$1.9 million. Of that, about half a million is directed towards home visiting programs. Most of that goes towards completion of an evaluation of the home visiting model called Parents As Teachers. The rest of the grant-making budget goes toward child care programs and early childhood programs, with the primary thrust to improve the quality. We have thought that the key to quality in early childhood programs is the staff. How do you ensure that you have well trained staff who are well paid and will continue in the program? The areas that we look at in child care have to do with general staff development training, workforce issues, and child care financing. How do you bring more money into the system to increase wages?

Let me first talk about Parents As Teachers. What I want to emphasize here is why our board thought it was a good thing to do. In 1987, several school districts came to our board and said, "We would love to replicate this great program from Missouri that we heard about." The school districts were located in the four-county area of Northern California that the board has paid close attention to over the years. The program focuses on children, which is a long-standing interest of the board, and it takes a preventive approach. Our board resonates to that and believes in the value of starting early to set children on a good path. Over the course of the past nine years, and probably continuing at least another year or so, the board has supported direct services in that Salinas area where the now nine school districts are collaborating to deliver Parents As Teachers services. The board also feels that an evaluation component is important. When they looked at the amount of money being put into services, they thought it was important to find out whether the money was making a difference. In addition, they were willing to fund a large, randomized trial focused on Parents As Teachers because they knew that Parents As Teachers is an important, national program, operating in over 1,600 sites around the country. Their hope was that from what could be learned in California there would be implications for national policy and practice.

The board also has challenged its staff to translate these findings into policy and practice. What are you going to do when we have the results from the evaluation? We will have results starting this year for three evaluations of Parents As Teachers. We are anticipating issuing reports and doing all of the other things you might imagine, such as presenting at conferences. I think that the other positive thing from our board's point of view is that we have established some ties with the Parents As Teachers national center. When the results come out, we hope that the nation-

Miscellaneous

al center will pick them up and use them to improve the practices of Parents As Teachers. The national center controls the training of home visitors for programs across the country. The goal is that they be involved in the evaluation, understand the results, and then translate them into practice.

Let me tell you a quick story about the history of the journal, *The Future of Children*. Again, this is a family foundation. The journal started because Dave Packard thought it would be a good idea. It was developed out of one meeting. We were thinking about the extent to which policymakers and practitioners in one part of the country might not know about what is going on in another part of the country. "Wouldn't it be great if we did not recreate the wheel, but get information out to people? Then they could cut down on some of their time and effort and make good decisions based on that."

We now have a journal that comes out three times a year. The explicit purpose is to influence and inform public and private decision makers. Each issue of the journal focuses on a topic related to children. The most recent issue focused on long-term outcomes of early childhood programs. An upcoming issue is going to be on special education. Another one is on child care financing. We have them slated for three years out, because it takes about two years to do each one. We have done issues on home visiting programs, the health care system, adoption, divorce, sexual abuse, and a variety of other topics. We send the journal free of charge to anybody who asks for it. On average, either the issue itself or an executive summary goes out to 40 or 50 thousand people. That includes policymakers such as senators and congressmen and their staff, people in the Administration, governors and state legislators, and so on. It includes Fortune 500 CEOs. It includes people in various fields such as medicine and law. Forty or 50 thousand people covers a lot of territory. It certainly goes to practitioners. It is our hope that it does help people. We are in the process of doing an evaluation to see if that is the case, and out of the results of that, we may think about tailoring our distribution or dissemination practices a little bit. That is a major activity of the Center, clearly designed to link research with policy and practice.

Let me end by talking about a grant in the child care area that, again, is designed to link policy with practice and research, but instead of going through an academic kind of approach or even using our journal, this goes straight to the media. The grant that we have made—and we are just one of a number of funders—was to the Child Care Action Campaign, working together with a group called The Communications Consortium, to start something that they call the Media Strategies Campaign. It involves a number of activities. The basic gist of it is to make sure that people working in the field know about new studies coming out so that they are primed and ready, when they hit the news, to respond to them. Then, because The Communications Consortium is a kind of public relations/media-savvy group, they know how to help researchers make sure that their message is conveyed, designed in a way that will capture the attention of the press. They work directly at times with researchers to provide them with media training. We did some of that when we released the long-term outcomes journal issue, and it was enormously useful.

This training means you are in a room for eight hours with video cameras and lights practicing the message that you want to convey. The P.R. people say, "Slow down, more emotion, movement." Also, they give you hints on how to relay the message with fewer caveats. We do not need to know all the interactions that are involved. It shows you how to be clear about what the message is, to understand how to convey that in a way that will be helpful to the press, and then to help you understand and learn how to answer questions of the press. It also is helpful for researchers and practitioners who want to know how to convey the important work that they are

doing and how to get some attention for that. The reason to do this is that many of the people that we want to influence on the policymakers' side do not read a journal like *Child Development*. They will never see the findings if that is the only place they appear. From our board's point of view, if that is the only place results out of a grant were to appear, they would not think that was a success. The goal of doing research is not to do a great study; the goal of doing research is to generate change.

Lonnie Sherrod: I would like to describe two other initiatives from foundations whose representatives wanted to be here. Both evolved from the report, *Starting Points*, that was produced by the Carnegie Corporation. The first initiative is from the Commonwealth Fund—Health Steps, which is an attempt to incorporate behavioral science and research on child development into pediatric practice in the U.S. It is an attempt to change the face of early child health care by using pediatric practice to promote the general development of children in psychosocial, emotional, and physical domains, in the context of the families and communities in which they grow up. It is a 15-site initiative that is just getting started. A pilot site will be operating this summer, with the remainder beginning across the next year. If you are interested in that initiative, I urge you to contact Katherine Young at the Commonwealth Foundation in New York City.

The other initiative is an early childhood public engagement campaign that is a broad-based, comprehensive, far-reaching attempt to disseminate what we know about the importance of early child development to the public, lawmakers, and policymakers. It is a collaboration spearheaded by the Carnegie Corporation, with funding from the AT&T Corporation and the Teresa and John Heinz Family Foundation. It will involve a number of specific components, including an hour-long ABC prime time special produced and directed by Rob Reiner. It will involve the following: 1) a special issue in the magazine, *Newsweek*, in which the cover story is on young children and their families; 2) a variety of public service announcements produced with funding from the AT&T Foundation in collaboration with the Ad Council; 3) the development of a new 800 number for people who see these materials and want additional information; and 4) a how-to video for new parents. These components are all planned and in the works. A number of other components, like development of a CD-ROM/Internet online information network, is being developed, as well as a conference on early brain development. If you would like more information, I urge you to contact Michael Levine at the Carnegie Corporation in New York.

Because it is a little different from the organizations and the programs you have heard, I will take a couple of minutes to describe the William T. Grant Foundation for which I work. This foundation was established in the mid-1930s by Mr. Grant. He established the Grant Foundation to understand how to help young people grow to their full potential. That has always been interpreted as a mandate to fund research on child and youth development. The foundation follows that mandate to this day. We spend about \$10 million a year. Ninety-nine percent of our portfolio is spent on research grants. We use an application and review process similar to what you find at a federal agency such as the National Institute of Mental Health and the National Science Foundation. It has two components. One is that we are highly competitive in our application process. Our board makes real decisions. We fund about 10% of the applications that we get. It is a review and decision-making process in deciding what we fund. That stems from the fact that we do not establish initiatives. We are investigator-initiated. However, we do announce interest. For example, until the 1980s, the foundation funded primarily research on infant development. At that time it was judged by our board that that field of research had developed to the point where it no longer needed the kind of funding that we provide. As a result, during the 1980s, we funded

Miscellaneous

research on older children, primarily early adolescents. Now in the 1990s, developmentally we have opened up our portfolio a bit and we will basically fund research on any age period, although there still is a disproportionate interest in older youth.

Let me give you a couple of examples of the kinds of things we fund in the early childhood area. Our researcher, who does basic research on socioemotional development in children and the role of emotions in regulating behavior, has focused most of her research on middle-class majority children in lab-controlled settings. She is launching a project in Head Start centers that is attempting to bring some of those ideas and research methods to minority populations in this real-world setting, and then asking how children's emotional behavioral regulation predicts success in making the transition from Head Start to school.

Another researcher, also a basic researcher who had studied the development of intentionality in infants, is launching a project with our funding in which he is asking about the parents'—often teen parents'—perception of the baby's competencies in regard to intentionality. To what extent does that mirror the infant's actual development and how do the parents' perceptions, whether accurate or not, then feed into subsequent development of the baby?

We have also, in a more proactive way, been involved in making sure that child development outcomes are included in research on the cost and the quality of child care, such as the study, *The Costs, Quality and Financing of Child Care*, that was launched out of the University of Denver. We have provided funding for much of the research looking at child development outcomes as a function of cost and quality. Similarly, in national evaluations of job training programs, the New Chance demonstration by the Manpower Demonstration Research Corporation and the evaluation of JOBS, the training program that emerged with the 1988 Family Support Act, we have funded embedded child development observation studies by researchers such as Byron Eglund at Minnesota and Catherine Snow at Harvard. These are observational studies of mother-child interaction in those evaluations, so that you can look at the impact of those programs on the parent/child interaction and on the child's development in the way that child development researchers typically look at it.

Audience Questions and Comments

Question: How did you choose the Free to Grow sites?

Marjorie Gutman: We chose the sites through a limited competition. For a national program with multiple sites, we usually put out an RFP, similar to the federal government's, to everyone within certain parameters. It might be for cities with over 250,000 people. In this case, we did not do that. We felt it would be unfair to put a lot of Head Start grantees through the trouble of proposals when there were only five slots. Instead we elicited nominations from the regional offices and from the national leadership. We received about 25 Head Start grantees as potential applicants. Then we launched a competitive process.

Question: The problem with federal funding for Head Start research is that it does a good job of developing models and short-term intervention. This is all well and good; however, one of the great advantages your foundation has over federal government-funded projects is that ultimately you want to see these four- and five-year-old children when they get to be adults. You want to see something that has helped them be more productive adults than their counterparts. Is

there any thought of a longitudinal follow-up once you get some models that seem effective, to look at these outcomes over 15 or 20 years?

Marjorie Gutman: That is an important question. The models have been pilot tested. They are starting to be implemented more widely. That is an option, to fund some kind of long-term, longitudinal research on these children. Whether we will do it or not has yet to be settled. A long-term, longitudinal study is rare for us, partly because we do not do basic research. However, we have just funded an eight-year initiative to work on the etiology of dependence on tobacco among young people.

Question: What are some of the other areas of research at the Packard Foundation?

Deanna Gomby: You remember I said it reflects the broad interests of the board. It ranges from ocean sciences to archeology and ancient study, film preservation, education, arts, youth, neighborhoods, child development, child health, and child abuse and neglect. There are five-year fellowships for young professors in the hard sciences.

Question: What percent of that is in California?

Deanna Gomby: In terms of the child and family, of that \$30 million or so, I would think maybe \$20 million is in California, because one of those grants is a \$10 million a year grant to Children's Hospital at Stanford.

Question: How are the overall initiatives for the foundations developed?

Deanna Gomby: This is another reason why I think the media is important. One of the things that our board reads is *The Wall Street Journal* and *The New York Times*. They watch "Sixty Minutes." All the things that you pay attention to are what they pay attention to also. Some of our projects are staff directed, and we are always proposing new ideas because we go out and talk with people, and people give us lots of good ideas. However, a lot of it is the board's own inclination about what they think is important. That means we go out and investigate what it is that can be done about problem X.

Marjorie Gutman: In our case also—the Robert Wood Johnson Foundation—the board's inclinations, preferences, and interests are certainly important. As Deanna said, they are citizens, just like everyone else. They are susceptible to the media. There is a bit of a difference between our two foundations. It probably has to do with less involvement from family. Robert Wood Johnson Foundation never had involvement from the family after General Johnson's death. The board tends to be ex-CEOs, business leaders, and professional leaders in government, health care, education, you name it. To put it in a nutshell, our agenda is more staff driven and less board driven; however, the board remains very influential. We still occasionally have situations where a board member will say, "How about X or how about Y?" But it is more staff driven in the sense that we have the four goal areas.

One thing I also want to correct is that I might have given the impression because I showcased *Free To Grow* that all of our funding is proactive. In reference to the earlier questions, the

Miscellaneous

staff thinks of ideas, comes up with a model, a program, and we fund it. About two thirds of our funding is done that way. We give about \$220 million a year..

Lonnie Sherrod: First I would point out the difference in size between these two foundations and Grant, that spends about \$10 million a year. Grant, until the past few years at least, was considered mid-sized in terms of overall foundations. However, there has been such a rapid growth of foundations in recent years: the increase in size of Packard, the Casey Foundation, for example, and the MacArthur foundation. Another large foundation is the Kaufman Foundation, which is similar to Packard in terms of redefining the program after an influx of funds. So the Grant Foundation is becoming smaller and smaller, as are some of the traditional foundations such as Rockefeller, Ford, and so forth. They are still quite big and in the top 10, but they no longer enjoy the stature vis-a-vis size that they used to have.

Marjorie Gutman: It is important to understand, too, that most of the proactive part of a foundation's agenda—the national programs, for instance, that the Robert Wood Johnson Foundation does—come from the field. People send us ideas about this project or that study. We go and look at it. That could become the basis for a national program or a commissioned study. For example, there was a project to do a program on nursing that we received unsolicited from an organization in New York City. It was an interesting idea for how to help low-income minority women get into the nursing field to advance their careers and decrease the nursing shortage. We funded this as an unsolicited project. We funded a second stage and then funded a national program based on it because it was such a good model.

Question: Can you address the issue of collaborative efforts?

Deanna Gomby: In the early childhood area, there is a group of foundations that have been meeting and discussing issues. There are also co-funded projects. Several of the projects that Lonnie mentioned, New Chance and the Cost/Quality Outcome Study, also was funded by us. With respect to evaluation, in being respectful of local programs and involving and adapting them—with the Parents As Teachers evaluation that I mentioned—the program site was involved in shaping the evaluation and in choosing the evaluation team. We sent out a mini-RFP for that. As it turned out, that was shaped in conjunction with the program. You cannot expect that you will get great results if you do not involve the people who are going to be studied. What it means from a funder's point of view is that you have to pay more money to the program in order to allow them to do it.

Marjorie Gutman: Robert Wood Johnson Foundation also is in favor of collaboration with other foundations and the federal government. On the other side of the coin, foundations are odd little animals. When they get together to collaborate, you have the odd little animals trying to collaborate and put together their different agendas, styles, boards, and so forth. It is challenging. Perhaps that is why it tends to take a bit longer than we all would wish for.

Lonnie Sherrod: It always amused me that many foundations will promote collaboration amongst the constituencies they fund, but rarely collaborate themselves. Part of it reflects this growth in foundations and the recognition that a lot of foundations share common missions. You can be much more effective by combining resources, wisdom, and so forth than by trying to oper-

ate individually, particularly those foundations that are smaller in size and have more limited resources.

Question: How can those of us out in the field find out more about opportunities in research?

Marjorie Gutman: The most obvious thing is to get on the mailing list of various foundations so that you get the annual report, RFPs, special reports, and newsletters. The Council on Foundations is a good way. First you need to target the foundations from which you want to get information. That is a good way to get broader information on multiple foundations.

Deanna Gomby: There is an organization called The Foundation Center that has its main offices in Washington, D.C., San Francisco, and New York, in addition to a variety of offices across the country, often in community foundations. They have books, catalogs, and all kinds of things. They will do computer searches to indicate the foundations available for early childhood funding and examples of the range of dollars that they are likely to give. They will give one-sentence descriptors of recent grants. You can get a sense from that of where you might want to look for funding.

Lonnie Sherrod: We cannot emphasize enough the importance of reading a foundation's annual report before you write to them. Researching The Foundation Center can be valuable. I cannot tell you the number of applications we get that are totally out of program, because obviously the word processor allows people to generate hundreds of copies, and they just blanket the world with them. That turns off foundation staff.

Comment: I think one issue that the Head Start community in particular needs to look at in terms of the policy issues is a dynamic shift from our traditional focus on child and family development to the general focus on welfare reform and moving people from a position of dependence on public assistance to more self-sufficiency.

Lonnie Sherrod: Different foundations are obviously thinking different things. Betty Hamburg, who is President of the Grant Foundation, has a saying that when you know one foundation, you know one foundation. That is how diverse they are. Most of the foundation work I know that has addressed welfare reform vis-a-vis completing education and job training has focused on the supply side; that is, how we give individuals the skills and motivation to enter what is a workforce that has increasing requirements on interpersonal as well as basic educational skills. Everyone is now beginning to realize that somebody needs to be seriously attending to the demand side; that is, the availability of jobs, the types of jobs, and the benefits that they offer.

Marjorie Gutman: Like my colleagues, I do not know what the overall trend is. In the case of Robert Wood Johnson Foundation, it has not changed. Over the years, it has been very stable. Periodically we have the discussion among staff of whether we should "farm out" the investigator-initiated, the unsolicited proposal. We always decide no. I do not know if you all realize that foundations tend to have small staffs. It would be more efficient, but we always decide not to because we feel there is definitely a value to the unsolicited, investigator-initiated items, because

they help us keep our ears to the ground. They help us to see what is going on in the field and to know what people are thinking about.

Question: In the public policy debate, there is a trialogue going on. One would be public, one would be private, and the other would be the independent sector. It seems that in some respects the government is trying to hold foundations and the independent sector from saying certain things about public policy issues, and yet, in some respects the independent sector may be the most effective broker on the playing field. What are your foundations doing to respond to that?

Deanna Gomby: There was an amendment last year, the Istuk Amendment, which talked about prohibiting many nonprofits from expressing positions about lots of things. Nonprofit groups are allowed to lobby for a certain percentage of their activities. However, this essentially would have eliminated that. There were a number of foundations that got together to take a position.

Marjorie Gutman: We were one of the foundations—Robert Wood Johnson—that was involved in that and tried to respond. I do not know if you realize that foundations are a certain type of nonprofit organization and have special tax codes. Foundations are prohibited by law from lobbying. This gets into legalese, but what it boils down to is lobbying—meaning trying to influence and speak out on specific legislation. It does not mean advocacy or public education regarding an area, a topic, or a set of options. We are not allowed to fund anybody to do lobbying on a specific piece of legislation.

In addition to the Istuk Amendment, there are increasing pressures. Robert Wood Johnson Foundation, for instance, has been wrestling for the past five years or so with whether to take a slightly more high profile, activist position vis-a-vis health care. Health care has become a much more controversial, high-visibility, contentious topic in our society. It was a decision of our board to be more visible and active in pushing for better health care, which is our mission. We have definitely taken some heat over that. More specifically, we are interested in tobacco and getting young people to stop using tobacco. We have been a little more activist and proactive around that. We have taken heat for that also. It is an ongoing discussion at the foundation, and among foundations, about how far to go and whether it is worth taking the heat and where that might lead.

■ Research from Historically Black Colleges: A Poster/Symposium

Chair/Discussant: Willie J. Epps

Symposia Presenters: Fannye Love, Beverly A. Bryant

Poster Presenters: Gloria Reed Alston, Evelyn Smith, Patricia Byrd Banks, Dorothy Riddick Johnson, Sandra Kay Gant, Debra S. Lutz, Gertha Mae Bond

The North Carolina Central University, located in Durham, and LeMoyne-Owen College, located in Memphis, TN, were two of six historically black colleges and universities funded by the Head Start Bureau to provide training for Head Start component coordinators and leaders. These two projects represent partnerships at their best in that both partners gain from the collaboration. Both projects have benefitted the Head Start Community by providing excellent training for Head Start staff, and the college and university have gained a new constituency.

An Historically Black College: Partnership to Train Head Start Professionals Fannye Love

Through this project, funds were provided to support 10 Head Start coordinators in a metropolitan area as they pursued a baccalaureate degree in Early Childhood Education. At the heart of the project was a functional partnership among four Head Start Centers (i.e., West Tennessee, Northwest Tennessee, North Mississippi, and Northwest Arkansas.) The ultimate goal of this partnership was to strengthen and enhance the quality of services provided to young children and their families by concomitantly strengthening and enhancing the knowledge base and skills of coordinators.

Prior to initiation of the project, a survey of the surrounding Head Start Centers was conducted. Consistent with previous findings, survey results revealed that 25 coordinators from eight centers had no formal degrees. A multidisciplinary committee was established to design a comprehensive program of training in appropriate general education and an early childhood education content, leading to a baccalaureate degree (B.S. in Educational Studies with a concentration in Early Childhood Education) for those 10 coordinators eventually accepted to pursue the program.

The selected coordinators represented various positions at the center, such as education coordinators, health/nutrition coordinators, social services coordinators, disabilities coordinators, and recruitment and eligibility coordinators. Because these individuals maintained their job assignments while enrolled in the program, the Committee designed an innovative delivery system to accommodate participant needs. The specific approach included combinations of an instructional module system, field-based instruction, and structured independent study. Beginning with the spring 1991 semester, coordinators enrolled in 12 to 15 semester hours of specified course work. Program offerings also followed innovative scheduling patterns such as Weekend College, with Friday evening and Saturday classes, or week-day courses meeting on Monday and Wednesday, or Tuesday and Thursday evenings.

The program provided support services for these nontraditional participants as well. For example, advisement and counseling were scheduled at times to accommodate their needs. The Education Curriculum Resource and Academic Skill Centers provided computer assistance, tutorial assistance, and other educational materials/resources as needed.

The project provided support for tuition fees, books, travel, and lodging for coordinators to attend local and national conferences (i.e., Urban Education Conferences, the National Association for the Education of Young Children (NAEYC), the Association for Childhood Education International (ACEI), and the Tennessee Association for Young Children (TAYC)). In addition to the unique professional development opportunities at conferences and conventions,

Miscellaneous

participants were provided with a myriad of field-based experiences in model preschool programs in public and private settings, thereby extending their knowledge of best practices.

The program has resulted in program completion for eight participants. For the remaining two, the program is ongoing with the final expected graduation date of spring 1996. The project produced eight fully competent graduates with newly developed skills, knowledge, and professionalism to make a positive difference in the lives of the children they serve. For the two coordinators currently enrolled, the project has already made a substantial difference in the programs for which they are responsible. In each case, the project has had direct and substantial benefits to children by producing high-quality and developmentally appropriate preschool practices in all domains of child development.

The following excerpts from formative and exit interviews underscore the benefits of the program: 1) developed a network of professionals to support coordinators as they develop professionally; 2) enhanced knowledge of child development theory, learning theory, and best practices; 3) fostered and supported innovation among the participants; 4) enhanced skills in providing for professional growth of staff around developmentally appropriate programs and procedures; 5) explored opportunities for integrated technology in instructional and management programs; 6) highlighted the importance of partnerships between higher education and service agencies in solving community problems.

Not only did this project have positive effects on the individual participants, their staff, and the children and their families, but it also resulted in benefits to the faculty at LeMoyne-Owen College. These faculty experienced renewed opportunities to glean first-hand knowledge of practical problems in child care programs and to design implementation strategies for their solutions. The coordinators and their programs provided the faculty with a renewed knowledge base on practice in child care centers and helped them to form professional partnerships extending beyond the duration of the project.

In summary, the partnership projects contributed in numerous ways to attainment of the central goal of the National Goals 2000 Agenda: "Every child will start school ready to learn."

Training Head Start Coordinators for Workplace Preparedness *Beverly Bryant*

The research results summarized in this presentation were derived from the academic capstone activities of 14 graduate student scholars and their five graduate faculty advisors who participated in a major project funded by the U.S. Department of Health and Human Services at North Carolina Central University. This project supported a cohort of experienced Head Start coordinators from North Carolina as they completed a rigorous graduate training program in early childhood education leading to the Master of Science degree. For each student participant, the culminating activity of this sequence was the investigation of a significant, field-based research question generated around issues consistent with the national priorities and professional practice needs of Head Start.

While the research detailed throughout this project was designed and carried out by independent investigators exploring quite different questions, their work with the related literature, their data, and their interpretations intersect in ways that present a consistent and coherent view and vision for Head Start. The view, of course, is of Head Start in North Carolina in 1995; it is composed of nurturing, caring, committed Head Start administrators, coordinators, teachers, aides, staff, and volunteers. It is fashioned with young children and families who have been given hope and opportunity where none might have existed before. It is testimony to the successes that

modest investments can achieve when expectations are high, missions are clear, evaluations are fair and consistent, and no one who should rightfully be involved is denied access to the process. It is a place where children can gain skills, self-confidence, and a sense of worth while being cared for and feeling secure, healthy, and valued. As our scholars remind us, Head Start children go on to succeed, and their families often progress with them.

These researchers also point to a vision well beyond 1995 and North Carolina. They see and show us a place and a time in our future when all children, from birth, will receive the nutrition, health care, security, skill enhancement, and social, mental, and academic support, which ultimately foster the conditions for real competence. We are told we need more and better quality training for teachers and staff; larger and higher quality facilities; more intensive involvement from families, especially from the males in these families; more articulation among all service providers; expansion of the pool of children we allow to participate; and easy, affordable, and attractive access to programs. Our research clearly suggests that these comparatively small investments hold our best hope of developing our children into citizens who are satisfied with themselves and with their lives, and who will be ready and willing to lead a nation that needs and deserves the advantages of their contributions.

Poster Presenters

The Impact of Male-Initiative Projects on North Carolina Head Start Programs

Gloria Reed Alston

This study is in response to a literature that strongly suggests that male involvement with their children is an important correlate with the child's positive cognitive, intellectual, and social development. Male-initiative projects are activities formally designed by Head Start programs with the specific objective of attracting and regularly involving the fathers and other significant males in the lives of Head Start Children. These projects attempt to identify the parameters of poor male involvement, enhance male self-examination and self-esteem, and stress the positive role fathers can play in promoting the healthy development of their children. The research surveyed 600 fathers or significant males of children in North Carolina Head Start programs. To gain broader insight and more generalizability of the issues, 237 Head Start administrators in the eight states of Region IV were also surveyed. The results are based on 182 father and 102 Head Start administrator respondents. Of the father respondent group, 80 percent were African American and 13 percent were White; most were under 42 years of age, with the modal group (40%) between 26 and 33 years old; about 55 percent of the sample identified themselves as single.

The results of the surveys strongly suggest that programs can have success in male-initiative projects; nearly 50 percent of those involved in such projects were rated excellent in terms of participation. Unfortunately, such projects are not as regular and pervasive as their successes would seem to warrant, and their effects and participation rates seem to diminish over time. The results augment the conclusions of earlier researchers in pointing to the need for more extensive and aggressive male-initiative projects, more research into the dynamics that lead to declines in involvement over time, and much more emphasis on activities that facilitate transition for parents as well as children from Head Start to public schools to assure that parental support, particularly from fathers and other significant males, follows children as they progress through school.

Miscellaneous

An Exploration of the Collaborative Efforts among Human Service Agencies and the Head Start Program in Four Eastern North Carolina Counties *Evelyn Smith*

This study examined the potential gains in both efficiency and effectiveness that can be gained by the planned and thoughtful articulation of activities of human service agencies among one another and with Head Start in Craven, Jones, Pamlico, and Carteret counties. Twenty-five human service agencies, of which 16 responded, and 22 Head Start staff members, including administrative workers, center managers, and family service workers, were surveyed from the four-county area. The survey was designed to solicit the perceptions of agencies and Head Start workers of the extent to which referrals were made and collaborative agreements were in place among agencies and Head Start in the areas of literacy, employability, substance abuse, housing, child care, and health.

Clearly, contacts with Head Start were initiated by agencies most often in matters of child care (68% of agencies), health (32% of agencies), literacy (25% of agencies) and employability (19% of agencies); no agencies initiated contact in matters relating to substance abuse. As might be expected given their relative missions, Head Start staff report relatively high rates of contact or referral by them to agencies, with affirmative responses ranging from 63 percent to 77 percent in all domains except substance abuse (36% yes responses). In those instances where agencies report linkages to Head Start, most are described as informal or working agreements with very few contractual agreements; the most common of these linkages are reported to be in matters of health, child care, and literacy.

When asked for preferred approaches to facilitate collaboration, agencies varied, with the most common preference being simply to "coordinate services". Head Start staff, on the other hand, clearly indicated that the best facilitation mechanism is to conduct meetings jointly (64%). Both agency and Head Start staff largely felt that the entire range of services was not "very available," with the one possible exception being the perception of the availability of child care among Head Start staff (54%). In general, human service staff do not find many significant formal impediments to collaboration; some feel federal rules and regulations or inadequate financing make collaboration more difficult, but they are a distinct minority. They do, however, largely agree that more staff with the responsibility to work at joint efforts would greatly facilitate collaboration. Clearly, most respondents are aware of the role of Head Start in facilitating collaborative efforts (100% of Head Start staff and 87% of all respondents).

Parents' Perceptions of the Parent-Child Centers in North Carolina *Patricia Byrd Banks*

This study surveyed parents of children attending the five Parent Child Center (PCC) programs included among the 45 Head Start Centers, in order to gauge parents' perceptions of the centers in the area. Respondents include 92 parents ranging in age from 14 to 43 years of age, 96 percent of whom were female. A 43-item questionnaire, including both Likert-type and open-ended questions, was used to solicit parent perceptions of the usefulness of parenting classes and the impact and quality of the PCC program and the GED classes that were available to parents, and to assess the desired level of involvement and strategies for involvement of fathers. Participants showed strong support for the usefulness (95%) and the positive effect on parents (92%) of the parenting skills classes; in fact, the vast majority (92%) reported that they would highly recommend the program to other parents and reported feeling comfortable at the Center. All participants in GED classes supported their appropriateness and role in forwarding their

efforts to obtain the diploma. Although respondents were evenly split on the issue of desiring more involvement between their children and the children's fathers (44%), most thought the father-child relationship was very important; respondents suggested that stereotypical male activities and accessibility after work or weekend events might encourage more male participation.

The author recommends that Head Start leverage the exceptionally high regard in which PCC activities are held by parents by conducting very regular evaluations, as well as long-term follow-up assessments, and by reporting results in aggressive marketing ways to funding agencies, policymakers, and new prospective parent participants. These evaluations could clearly form the basis for modifications in program activities and serve as a communication mechanism with parents. The respondents of this study also suggested a number of additions and alterations to adult activities that might improve their usefulness, including more individualized instruction in math and English, and the inclusion of some practical-life skills such as driver's license acquisition.

The Impact of Head Start on Long-Term Academic Achievement *Dorothy Riddick Johnson*

The author of this study investigated a matter that is considered among the most crucial to the success and ongoing financial support of Head Start programs. Data was secured, analyzed, and interpreted from 375 high school seniors in Region "R" of Northeastern North Carolina. The sample included 79 individuals who had been Head Start students for varying, but significant, periods of time (53 for one year, the remainder for two or more years). Of the total sample, 53 percent were female, 32 percent were White, and 65 percent were African American. Data on student perceptions of academic success, sources of academic influence, and the impact of Head Start experience were gathered using survey instrumentation.

In general, the results of this research support earlier studies that suggest that children's Head Start experience promotes both their short- and long-term academic and personal success. Respondents with Head Start experience report that they were given a positive early start, were better prepared to enter school, had increased self-esteem and enhanced social skills, and were more likely to engage in leadership activities. In each of the academic and personal domains examined, former Head Start students reported equaling or exceeding the achievement and satisfaction reported by their peers who had not attended Head Start. Particularly encouraging is the apparent tendency of former Head Start students to emphasize positive personal characteristics, community-enhancing activities, employment and career goals, and a willingness to work hard to achieve their goals. While school retention rates were slightly higher for former Head Start students, retention typically took place at a very early grade while non-Head Start students were often retained in much later grades; students with Head Start experience report more daily interest in school, and drop-out rates were very low. The author cites the family involvement aspects of Head Start as a critical variable in the long-term academic and personal success of children, and recommends the expansion of Head Start programs to all eligible children and the provision of significantly more Parent-Child Centers to extend these positive family influences.

Multicultural Education in Head Start Programs in North Carolina *Sandra Kay Gant*

This study explored the pervasiveness and apparent impact of multicultural education curriculum materials and approaches. Moving beyond a literature that strongly suggests that the Head Start target age group possesses prime developmental potential to recognize and appreciate individual differences, the author studied the various ways Head Start programs integrate multi-

Miscellaneous

culturalism into their activities and how such activities are perceived and influenced by both teachers and children. Responses from 162 Head Start teachers from 32 programs representing 48 of the 100 North Carolina counties were analyzed and interpreted, and 69 children were interviewed from Head Start programs in three counties that were introduced to a multicultural curriculum. While most of the teacher sample was African American and female, they were quite diverse in age and experience. Exactly half of the programs used a commercial multicultural curriculum, whereas all reported implementing some specific multicultural activities; 100 teachers report implementing a "heroes and holidays" approach to multicultural education, but many used daily activities. Restriction of range in the race, gender, and age variables among children make difficult the interpretation of differences in how children viewed themselves and others, but it seems multicultural activity does promote enhanced self-esteem and self-concept, cultural and self-awareness, and social skills.

Given that the findings support and expand upon earlier literature, the author strongly recommends that all Head Start staff be trained to implement all component operations consistent with Head Start's 10 Multicultural Principles; that the culture and ethnicity of the Head Start regions and program enrollees be carefully considered in planning for daily multicultural activities; that multiculturalism be an integral element in planning for the development and enhancement of children's self-esteem, socialization skills, and self-awareness; and finally, that all Head Start programs be examined to assure the implementation of multiculturalism in their curriculum.

An Analysis of Parent Involvement: The Impact on the Families of Head Start *Debra S. Lutz*

The author expanded upon the research base and fundamental principles underlying most Head Start components that suggest the importance of parental involvement in advancing Head Start objectives. Her sample included 17 Parent Involvement Coordinators and 61 Family Service Workers from 17 Head Start programs in North Carolina. Respondents completed two surveys intended to assess activities engaged in by parents, as well as staff perception of parental attitudes and behaviors.

Subjecting the resulting data to a series of t-tests led the investigator to conclude that staff members who had been Head Start parents themselves were significantly more likely to participate in program planning, and showed significantly higher overall receptivity to parent involvement than did staff who had not been Head Start parents. Additional tests suggest the education level of the teacher is largely independent of the extent of parent participation and the amount of parent involvement in planning, as is the staff role (teacher, coordinator, family service worker) and the extent of individual participation of the parents. The author also found that the staff of a clear majority of programs perceive the level of parent participation to be quite low; participation levels seemed to not be much enhanced by the parent orientation efforts in which their programs engaged. Even so, most programs felt that they had parents who were doing some volunteer work on a regular basis. Because parental involvement is viewed as promoting the academic growth of children and because the staff perceive parent participation to be encouraged more in programs that hire former Head Start parents as teachers, programs apparently are putting a priority on replacing staff with individuals who had been Head Start parents. Staff respondents did exhibit some concerns that parents who became teachers often do not very aggressively pursue further education. Finally, it seems apparent that not all components of Head Start programs place a priority on parent involvement. The author strongly endorses the concept of full parental participation in all components of the Head Start program, as well as encouraging administrative support

for parent and staff training, stimulating policy formation to promote parent involvement, and rewarding positive actions by teachers and other Head Start staff who develop and nurture strong relationships with parents to facilitate the academic and personal growth of Head Start children.

The Knowledge and Attitudes of Head Start Staff and Parents toward Children with Blood-Borne Pathogens *Gertha Mae Bond*

This research responds to contemporary issues raised in public health and educational settings with respect to the increasing spread of blood-borne pathogens. The investigation sought to determine the ability of Head Start staff and parents to identify blood-borne pathogens, to assess their knowledge and attitudes related to these pathogens, and to gain insight on the elements needed for developing a training module for both groups. Data were gathered from 90 Head Start staff and 38 Head Start parents who responded to the nearly 800 surveys included in registration packets at the 1995 North Carolina Head Start Association Conference; nearly all subjects were female with only three respondents identified as males (4 respondents did not identify their gender).

While respondents had some difficulties in producing free-response definitions of such terms as AIDS, HIV, and hepatitis B, they were uniformly able to describe the symptoms, transmission, common misconceptions about, and the effects of the pathogens. When asked to provide specific responses to health policy matters, significant numbers of parents and staff were knowledgeable of clean-up precautions, but nearly 30 percent of each group did not know recommended disposal methods. Parents and staff both showed considerable disagreement within their groups about attitudes toward children with blood-borne pathogens; nearly half of each group disagreed that the HIV virus could be transmitted by a bite and whether a bitten child would need a blood test. The groups were similarly split on the issue of informing all staff of the HIV status of children. A clear majority disagreed that staff should refuse emergency care to an infected child; about half agree to the concept of HIV testing of adults who work with preschool children.

Coupled with responses to other items, the investigator concluded that parents and staff are fundamentally quite knowledgeable about blood-borne pathogens, but that some basic training seems warranted. In a series of questions related to attitudes toward children whose health or behavioral status might raise concerns about blood-borne pathogens, parents and staff largely agreed with each other and exhibited fundamentally supportive and nurturing attitudes toward such children; still, some uncertainties and insecurities suggest to the researcher that more training is needed.

■ Positive Aspects of Media on Children

Chair: Sheryl Brown Graves

Presenters: Valeria Lovelace, Sheryl Brown Graves, Ranny Levy

Ranny Levy: The overall concern of the Coalition for Quality Children's Media is to help a body of work that we consider to be quality children's programming to have a greater visibility with parents, teachers, and caregivers, and also to help make those titles more readily available. The project is called Kids First. In order for a title to be approved by Kids First, it goes through a very stringent evaluation process. We have a national jury of both adults and children who evaluate titles using an evaluation tool that was designed, with the help of the research department at Children's Television Workshop, specifically for this program. There are over 300 professional adults and 3,000 children who participate in the evaluation of the products.

One of our concerns is the home video market and entertainment programs that have a cross-over value in educating children. As we know, children learn from everything they see. They spend 15,000 hours watching television during their school-age years at the same time that they spend 11,000 hours in the classroom. Anything approved by Kids First has to pass the baseline criteria, consisting of no gratuitous violence or sexuality; no verbal or physical abuse; no bias in terms of race, gender, culture, or religion; and no condescension toward children. Anything containing one of those elements will automatically be eliminated.

Interestingly, when we started this program, people wondered if there were any quality programs besides "Sesame Street" and "Mister Rogers." We have endorsed over 600 video titles to date, and we began last year to evaluate CD-ROM programs as well. Many of these are titles that would otherwise be lost in the marketplace. Shelf space in stores is essentially owned by the company, whether it is Warner Brothers, Paramount, MCA, or MGM. We wanted to make the public aware of a body of work that was judged on its content, as opposed to how many dollars went into its marketing.

Beyond the baseline criteria, we are also concerned about four other general aspects of a program. First is the appeal. When we work with the adult jury we are interested to know if they will be interested in viewing the program with their child. We know that this will have an influence on how readily the child will have access to the program. On the children's form we also ask: Did you like this? Would you like to share it with a friend? Would you like to watch this again? Would you like to have this in your home collection? Second is the content. This is the single most important category we look at. We look at whether it is relevant to the age group it is designed for. However, if something is weak in content, for example, a music video that does not have strong cultural messages but is appealing and does not have anything damaging in it, we may still think it is a good program for children to watch.

A total number of points are given to each of these general categories: up to 10 for content, up to 10 for appeal, 10 for production quality, and 10 for overall benefits. When a title scores very high in all of these areas and receives a "yes" from our jurors, they then have the option of recommending it for what we refer to as an "all-star." That is something we consider to be appealing to just about any child. Any parent can pick that tape off the shelf, take it home, play it for their child in the appropriate age group, and they will like it. Sometimes there are some qualifying factors that the jurors feel need to be taken into consideration. Is the pace a little bit too slow or too fast? Does it appeal to a special audience? Does it have the appearance of being culturally diverse, but the jurors feel that it really does not work in terms of portraying diversity? Is

there some stereotypical behavior prominent, but not offensively so? In these cases, it is given a "qualified yes" rating, and we also publish the comments from the jurors.

The last thing on the form is for the jurors to indicate what they feel is the most appropriate age group for the title. Initially, when we started this project, we found that we would receive many titles, especially from the large companies, that would indicate a very wide age range, for example, for ages 2 to 92. How many titles are really suitable for 2 to 92? So we made them narrow their suggested age range, and then we test that with the jurors. An adult juror first makes a recommendation, and if it differs from the age group that it was submitted for, it will be tested with that group of children. In that way, we find the more appropriate age groups from actual viewings by the children. Those numbers are published as well.

The last thing we do is publish a directory, listing the titles that we have approved. We do not publish lists of titles that are rejected. Along with each title listing there is a description, the jurors' age recommendations, any jury comments, and the name of the company that released the title. We do not sell titles or in any way act as an intermediary in the distribution. Along the side of the directory we have a sidebar of tips for parents that answer the most frequently asked questions about children's programming.

Audience Questions and Comments

Question: Are you a nonprofit organization? People have divergent opinions about religious issues, issues of sexuality, and so forth. How do you resolve what is developmentally appropriate on these topics?

Ranny Levy: We are a not-for-profit organization headquartered in New Mexico. Our jurors are in 33 states. Issues of religion or sexuality are dealt with through the selections of the jurors. The jurors who participate have to have an academic background and advanced degree in either education, child development, children's library science, or a similar field. We feel that by selecting qualified jurors to be a part of the process, we leave that interpretation up to them.

Question: What is the relation between Kids First and the coalition?

Ranny Levy: Kids First is a project of the coalition. The coalition is essentially a joint effort between three different stakeholders: the media industry, child advocacy organizations, and educators and academics. Groups such as the National PTA, the American Academy of Pediatrics, and the YWCA are all involved members of the organization. They work with us to help disseminate the information that we publish.

Question: Where does your funding come from?

Ranny Levy: Our funding comes from what I call a complex matrix. We are not funded by the government. We are funded by private foundations and corporations. We have major industry members who support the organization, although their membership in no way guarantees them an endorsement of their program. That is something that is always tricky when you go about getting their membership renewal and they have had rejected titles. We have groups such as Sony, MGM, MCA, BMG, and Twentieth Century Fox who support this initiative.

Miscellaneous

Question: How long has this project been in operation and how do jurors work?

Ranny Levy: Since 1991. We send out the tapes to the jurors. They work independently of each other, although we put groups together in audio conferences from time to time to discuss specific issues that come up. Then we make copies of those audio conferences available and send them out to all the rest of the jurors. If any of you would be interested in participating as jurors, we would love to have you become involved with us.

Question: How do you handle debate among the jurors? Do you go simply by numbers? Does it have to be 100% agreement before a decision to include a certain medium, either a book or a video, or just a majority vote?

Ranny Levy: Everything has to meet the baseline criteria in order to get an endorsement. If one juror feels that it does not meet the baseline criteria, we will do a staff review and set up a secondary committee to look at it. It does happen occasionally, although 80% of the time, the jurors are pretty much in agreement. The yes's get the yes's, and the no's get the no's, and the things that are questionable fall in the middle pretty clearly. We have to have a majority approval on any title beyond the baseline criteria. That is the one thing that we are very particular about. If any one juror feels that it does not meet the criteria, then it goes into a re-review process.

Question: How many people on average review entries?

Ranny Levy: Five adult jurors review every single title, and then those adults have a committee of children who review it as well. We ask that they have from 5 to 30 children for videos, and from 3 to 30 children for CD-ROMS, so any single title could be looked at by 150 children.

Question: Then you have not tackled the regular series on TV?

Ranny Levy: No, although we are going to do a pilot project evaluating television programs later this summer. One of the difficulties, of course, in getting into rating television is the huge numbers of hours that you are looking at. We have designed the pilot to zero in on a certain time frame, on a certain day. We are setting up a jury within a single community. We will engage people within that community in that jury and see what happens, then look at the process from there.

Question: Didn't Action For Children's Television monitor television programs at one time?

Ranny Levy: They did some monitoring of television programs, and they also had an awards program for videos when the organization was still active. How this differs from an awards program is that rather than limit the number of titles that can receive an award during the year, virtually any title that qualifies could get a Kids First endorsement. We wanted to be able to include any title that met the criteria set up by the organization and not limit it to the absolute best of the best. There is a wide range of products, from those that just meet the criteria and that children like but may not watch repeatedly, to those that they might watch more than a "Barney" tape.

Valeria Lovelace: Dr. Sheryl Graves has written extensively about diversity and television. She has been in the forefront of evaluating commercial and public television. She will share some remarks and comparisons of what exists now and what has existed in the past in terms of diversity on television.

Sheryl Brown Graves: That last clip that we saw from *Preschool Power* is unusual from the perspective of diversity. That is, we saw examples of children from different groups, and we saw them all positively portrayed. That is highly unusual for commercial or entertainment television. The social world of television is dominated even today, after many years of study and after hoping that it would change, by White, middle-class males. There have been some changes, but, as we continue to do content analyses, we come up with the same overall pattern. There are variations, and I will respond to some of those variations.

When looking at diversity on commercial television, the group most frequently represented is African Americans. Latinos are next. Asian Americans are very hard to find, and Native Americans almost do not exist unless they are in a show that comes from Alaska. We seldom see Westerns, although we do have "Dr. Quinn, Medicine Woman," which gives us the opportunity to see a Native American.

It is very interesting because not only is commercial television very stereotyped and limited in what it shows, but there are variations by networks that are interesting. There was one study done in 1993 that looked at Saturday morning network programs. In that sample, any child who watched Saturday morning T.V. that season on CBS would never have seen an adult who was from a minority group. There was no ethnic variation from about 7:30 or 8 o'clock in the morning until noon. On the other hand, if you had watched NBC during that same time slot, you would have seen more representation of diverse individuals. So, not only does television only present a particular social fabric of human beings, but you may have even less of whatever it is that commercial television has to offer by network and by time slot. It is a very interesting dilemma.

On public television, parents and caregivers have a totally different perspective. If you turn on children's programming on public television, you are almost assured to view diversity. You will see African-American, White, Latino, and Asian children, children with disabilities, and children who speak different languages working together, playing together, laughing together, seeming to get along. Yet, if you go beyond that haven of public television devoted to children, the commercial and cable networks will flood your children with a totally different image.

The other thing that commercial television does is segregate groups. Even when African Americans appear on television, they tend to appear in what we like to call in the television research world "ghetto gulches." African Americans in the ghetto gulches are almost always in situation comedies, and somehow the physical appearances are exaggerated because that is part of the fun. We are laughing at ourselves, or other people are laughing at us. So we have diversity, but it tends to be segregated. When it is an African-American show, there are almost always no White people. If it is a White program, there are almost always no minorities.

If you look for the recent trends in adult situation comedies, like "Friends" and "Seinfeld," they all live in New York City. Yet they have no contact with people that look like Valeria and me. Never. As a person who works in New York City, I find this interesting. They walk down the streets and there are only Whites. So again, we are finding a re-segregation, if you will, or a homogenization of what we see on television. This is true in programs for both adults and children.

The diversity in television also works in very interesting ways when it comes to gender issues. The rule in commercial television is that you create a program that male children will watch. They know that female children will watch programs that male children will watch. The rule is, if only girls are interested in it, then boys will not be caught dead watching it. If it has pink or purple as a prominent color scheme, boys will not watch it. If the program is about a lot of little children or is too nicey-nice, boys are not going to watch it. Advertisers will not go for children's programming directed at girls, because boys avoid it. They will go for a program that is only aimed at boys because girls learn very early on that you have to be more open-minded. You have to engage yourself in activities and interests of people who are different from you.

I have my students in my child development courses watch the television shows that children watch. They always hate this exercise. I ask them to find me the shows that are directed at girls. One of my students came back and said she found an adventure series that has female characters, "X Men." Now, she was not incorrect. It does happen to be an action adventure series that has a female character, but the title of the series is "X Men." I suggested that if they were really interested in highlighting the fact that this was a gender-diverse group, they could have called it the "X Team" or the "X Group." However, they called it "X Men" for a reason.

You might wonder if this matters. Valeria demonstrated to us that it does matter. We have evidence from children's own words and actions about why this matters. With television, they see over and over again examples of human beings in the social world. It shows them how people get along together or do not get along together. It shows them how to solve a problem and what to do if they disagree. When diversity is presented on commercial television, it is almost always in a work setting. At work you have to deal with diverse people. However, it is very rare in the world of television that diverse groups interact in social contexts. They do not visit each other's homes. They do not go out to lunch, go to a movie, or go see art together. At work they are in an office, and somehow people have forced them to be there, so they are moderately civil to each other. As a result, we get the kinds of findings that Valeria mentioned concerning children's attitudes about why people should not be interacting with each other, why they should be separate. It is not only from their own personal life experience, but also from the extent to which children use media—and they use it often—that the media reconfirm those messages.

One of the things that I want you to think about as we move into this new information and technological age is that television is going to be hooked up to all kinds of sources. Right now we watch television, but we do not always watch broadcast television. We watch a videocassette or cable television. Some of us who have more money can watch a television that is connected to a compact or laser disk machine. Soon we will have access to the Internet via our television sets. We must be increasingly aware that no matter what the source of the content coming through this box, we are going to have to use criteria and evaluation strategies for that content.

Unfortunately, every time we move into a new kind of medium, much of the content from the old is simply recycled. When you look at cable television, there are old shows that have come back on, and this generation of children watch them on cable. Therefore, images from the 1970s or the 1960s that we would find questionable are now being rebroadcast. One has to be ever-vigilant with the content that is going to come through television.

One last thing—we do have the ability to make television more positive than it means to be. Public television intends to be positive; it works very hard at it. It calls in advisors; it does research and tests it with children. Commercial television spends more time trying to figure out how to get the largest audience in front of the commercials inserted around the show. If they could figure a way to show us commercials 24 hours a day and have no programming, they

would do it, but so far not even children will watch commercials for the half-hour segment. As adults, we have the capacity to make commercial television useful. First of all, we can tape a show. Then, the program can be shown at any time. And remember, you do not have to show the whole program. You can show only the five minutes you think are interesting. Children are used to not watching things from the very beginning to the very end. They are perfectly content to watch a clip and talk about it. You can link it to information that you want children to have. You can use it as a source of discussion. You can take something from a commercial television program that had no educational content or intent in mind and use it as an opportunity for discussion. Link it to a book that you want a child to read. Have them write or draw something about it. This is the capacity to shape and mold and make these programs work for us.

This is also an opportunity to teach children to be more intelligent consumers. Children are perfectly capable of developing analytical skills—of stepping back, thinking, and learning whether a program is good. Was it interesting? Would I show it to my friend? Would boys like it? Would girls like it? Children have these capacities, and we can at least help them generate and develop these capacities. It can turn out to be a fun activity for children, making the media experience a much more active and interactive one.

Audience Questions and Comments

Question: I am interested in your reaction to Power Rangers. There, you have an ethnically diverse group whose race is extended beyond their own skins to their costumes. My experience with children of all races from very casual observation is that everybody likes the white ranger and the pink ranger. I do not know if that has been studied systematically. Also, could you respond to the violence?

Sheryl Brown Graves: The problem with the Power Rangers is that it has an ethnically diverse group who are cooperative, but cooperative for what purpose? The reason that the two you mention are generally picked is that these are the two who appear to have the most status in the group. In terms of when the dolls came out, these are the ones that were most readily available. Children are very intelligent at picking up on subtle status cues and subtle power cues to identify with. You want to identify with the person who is the strongest, the most important, and who appears to be the leader. And of course, they know the larger social message about colors and the symbolic meanings behind them.

Ranny Levy: The overwhelming message in Power Rangers is that they solve problems by using physical force and violence. Perhaps they are reaching toward a redeeming end, but it is problem-solving through violent solutions, not by using their wit, cleverness, communication, or anything else.

Question: Are we conditioning children to watch at any point in the program and not have to watch from the beginning? Not to knock Sesame Street, because it is one of the few quality shows for young children, but it is rather fast paced, and there is not necessarily a story line, but rather separate segments that move quickly. Are we conditioning children to not have an attention span for more than two-minute segments? I was wondering if that has ever come up in your

research? Is that how children like to watch television—to watch it for two minutes, go play, and come back? Or can they watch a 30-minute show?

Valeria Lovelace: The reason why Sesame Street was designed that way was because of the whole discussion around the short attention span of preschool children. In the reality of actually testing and watching children, it is very content driven. If there is a good show, if we have a story line that the children like, they will watch it for 10 seconds, or they will watch it for the whole hour. We had Slimy, our worm, whose mother gave birth. It was a very intense show where the father was in an airplane and was not going to be able to be there for the arrival of the new child. The children were riveted for a whole hour. They did not move. They wanted to know what was going to happen with Slimy and the new baby. Then there are moments on Sesame Street when children are making systematic decisions. They monitor it auditorily. Even though they may be off playing, they are still listening to find out what is on. They will check back just to see if it has changed. If it is something that they like, they will sit down, watch it, and then monitor again, and figure out if they want more. It tells you about the motivating force within the child to select what he or she likes. Children are very selective viewers.

Question: In your luncheon talk you presented some interesting and sobering findings from the Race Relations Initiative. You did not tell us where you are going with it. Is there a follow-up on those findings? Are you trying to look at some ways to make the interventions more explicit, or have you decided to stop that and move in different directions?

Valeria Lovelace: We are analyzing the data. We had children watching each other—each group watched segments from each other's group. There is much more of a story to tell about how the children responded. In addition to that, we collected a tremendous amount of baseline information from all of these children that we have yet to discuss. For example, we have replicated the doll studies in many versions with many different types of dolls. We have done it with Barbie dolls, with some other kinds of rag dolls, and so forth. What I am headed towards is a book to tell the story of what has happened, not only in terms of the research with the segments, but also the tremendous amount of baseline information that we have. The goal is to present this information so that people can begin the process of developing materials that address it. The key to this is that even with the information, you need to test what you create. That is the challenge of making sure that your attention is followed through and understood by the children.

Question: Have the particular segments that you used to illustrate today actually appeared on the air or are they just used for research purposes?

Valeria Lovelace: They have appeared on the air. Sesame Street is experimental. We do not air anything that we feel is damaging. For example, when we created a divorce show, we tested it before it aired, and we found that it frightened and disturbed children. Therefore, it would never be aired. In the case of something like this, it is not perfect, but it is also doing no harm in terms of beginning the process, and we try to give feedback to the writers and producers to produce more. All of the research goes back to the writers and producers first; they build on it and continue to create additional segments. It is a very slow process.

Question: You were mentioning today that ages three and four have responded in a certain way, and then by five you started getting some of the more racial stereotyping. I was reminded of something one of my colleagues, Lois Hoffman, has often talked about. She has two daughters whom she schooled to want to become doctors and lawyers. When one of the daughters became six, or was in first or second grade, she thought she was going to be a nurse. The socialization from the school setting had overpowered the socialization her parents had given her in terms of the conviction. It turns out that she is now a pediatrician. Lois prevailed. However, she went through a rough time. I have a feeling that the same kind of factors start to operate as children get more and more exposed to that real world of school.

Sheryl Brown Graves: I think it starts even sooner because the children are letting us know that they are not seeing these behaviors or attitudes in their own households. Some of us would like to think that parents have positive attitudes around these issues, and that it is only once they get to school or they go outside the home that they are going to run into negative attitudes or encounters. Some research on preschoolers was done at Cornell in which researchers went into homes to look for evidence of diversity in the child's environment. They looked at books, magazines, toys, and games. In most households, there was absolutely nothing. That is a message. For adolescent boys it is much more ethnically diverse. If they like baseball, they have Latino or African-American baseball players that they are interested in. However, when you look in a lot of homes, there is no evidence of diversity. There is not a single toy of a person from a different racial or ethnic group. We know that children learn a lot from what we say, but they also learn a lot from what we do or do not do.

Ranny Levy: I would like to go back to what Valeria was talking about earlier today in terms of television programming. PBS has taken the initiative in providing a positive role model. It may not be representing our culture as we experience it today, but it does certainly provide something worth striving for. It is one of the things that we pay a lot of attention to as we look at programming and giving feedback to the producers. We actually had people saying to us in this last round of rejections and endorsements that they were paying attention to the feedback that we were giving them, and they were going to use that as a role model for their future acquisitions.

Comment: There was no diversity among the persons in "Toy Story." There were some colorful toys, but there were no colored persons. It was a long-running motion picture that received numerous awards based on its advancements in computer imaging.

Ranny Levy: Well, attendance and turning off the machine are in your control. I do want to point out a marvelous title that was released this year and played on the Disney Channel, and is available on the home market called "People," based on Peter Speer's book, *People of the World*. It was adopted by the United Nations as part of their 50th anniversary celebration in October. If you have not seen it, you should definitely make a point to do so. The entire program is about cultural diversity and how people live differently. They live in different types of houses. They eat different foods. They have different habits that they go through their lives performing. However, they all tuck their children into bed at night and give them a kiss. It has all the similarities as well. It is a wonderful piece.

Miscellaneous

Comment: There is a challenge to us as adults to be honest and frank about where we stand with respect to our acceptance of others who come from different backgrounds. We have a tremendous responsibility in terms of living up to this idealized notion of being able to all live together, although we may be different. It must not just be left up to the media, for we really do have a responsibility to do what we need to do for our children. We want that acceptance of difference that is there very early in life to continue and not get derailed when the children enter school. I hope that others walk away with that challenge as well.

Comment: We are currently working on a partnership using the Sesame Street materials redesigned to train home care providers to use television in a positive way with books, activities, and things like that. In three years, we will train close to 400 home child care providers across the country. We are excited about an opportunity to use television as a tool that is readily accessible in helping to educate in a positive way.

Comment: We, too, have been using some of those materials for training teachers in North Carolina, and, in addition, we are using the internet in North Carolina. You have at least piqued my interest about how we might better think of having, even if it is artificial, something that will help formulate and change some of our attitudes on diversity.

Ranny Levy: Last year at the World Summit on Children's Television, there evolved an international research forum that has an online group. If anybody is interested in joining that, I will be happy to connect them. We may be reached by e-mail at: kidsfirst@santafe.edu.

Question: When you create segments for Sesame Street, do you talk to children first to get their feelings or what their experience is?

Valeria Lovelace: Yes. In the case of divorce, we actually talked to children, and we also talked to experts. We had two populations we were trying to talk to: 1) children who were going through divorce or who had experienced it and 2) children who may have seen friends' parents or their parents argue, and for whom we wanted to allay fears. We created a show that dealt with both populations. That was probably a mistake. We did not spend enough time showing the adjustment process of Snuffy, whose parents were getting a divorce, how he was going to be okay, how things would work out for him, and that he would be taken care of. The experts gave us a tremendous number of messages, but we did not know how to prioritize them. We did not know what was the most important thing to do. Based on this research experience, we are now very confident. If we go in this area again, we would spend the majority of our time showing Snuffy visiting Mother and Snuffy visiting Dad. We would show the love, the sharing, and that life goes on. That would be for all the children, whether they are overhearing arguments, scared, nervous, or whatever. We underestimated the message that life goes on. We dealt with some anger, some fear, similar to what I was talking about earlier. That was too volatile for the children to handle. We had some expressions of real frustration on the part of little Alice, being angry with her doll, playing out some frustrations that she had. The children immediately started talking about Freddy Kruger and killing. They were saying that Big Bird was going to kill the father. They were extremely elaborate once those emotions were triggered, without us spending the time to really deal with the adjustment and showing that things were okay. So we learned a lot from that experience.

Question: What type of follow-up do you do after you have shown an experimental segment to children?

Valeria Lovelace: Basically, we work with the day care directors, and then they work with the teachers and with the children themselves. We showed it to 60 children, but they helped us stop something that could have harmed millions of children. In and of itself, it was worth showing it to a few children with whom we could actually follow up.

There is a lot more that we can do in terms of positive television and media for children. One of the main things is that we have to be advocates and demand things from the industry that we want. This is empowering. I will never forget when I worked in a television station in Topeka, K.S., as a volunteer. For the majority of the programming, we did not have ratings. Our PBS station was small. We had no way of knowing whether or not people were really watching the majority of the programming that we were sending out. Every now and again, there would be a woman who would write a letter about the quilting show. She would say how much she enjoyed it, how good it was. We kept that quilting show on the air based on that one letter. You have that much power. Very few people are writing to the networks or to the producers to tell them that they are doing something good. The extent to which you can pick out any little sliver of something good and write to the people who produced it will encourage them and give them support to be able to do more.

Posters

Maternal Variables, Home Environment, and Toddler Test Behavior and Performance*Cynthia Pierce Liefeld, Joan I. Vondra, Richard Solomon*

Presenter: Cynthia Pierce Liefeld

Data were collected during a home visit with 50 urban, low-income teen mothers and their two-year-old children as part of a longitudinal study. Half of these teen mothers and their infants participated in a multifaceted parenting support program starting shortly after birth. The other half represent a demographically matched control group.

Independent examiners administered the Bayley Scales of Infant Development (BSID) to derive a Mental Development Index score (MDI) of each toddler. Examiners completed the Infant Behavior Record (IBR) and the infant/toddler version of the Home Observation for Measurement of the Environment Inventory. Self-report data were collected, including a measure of maternal depressive symptomatology.

A factor analysis of IBR items revealed a single factor we have called "mastery motivation," a combination of items that emphasized "how well a child tests," and was relatively independent of testing performance measured by the MDI ($r=.302$; $p=.035$). Two hierarchical regression analyses were conducted with the scores of toddler testing competence (i.e., testing performance (MDI), and mastery motivation scores were regressed on maternal age, level of education, repeat pregnancy status, maternal depressive symptomatology, quality of the home environment, and participation in the parenting support program).

Race, maternal age and education level, and repeat pregnancy did not significantly account for any of the MDI variance, although the change in R^2 after adding the variable Repeat Pregnancy was significant ($p<.05$). After controlling for these factors, self-reported depressive symptomatology and the quality of the home environment provided significant prediction ($p<.05$) while intervention group membership provided marginally significant prediction ($p<.10$) of toddler variability in overall test performance ($F=2.19$, $p\leq.05$). These findings lend support to our hypothesis that maternal depression and an increase in family size contributes to poorer developmental outcomes in children of adolescent mothers.

The same set of variables accounted for only a marginally significant proportion of the variance in toddler mastery motivation ($F=1.91$, $p<.10$). Maternal race and age were each significant in predicting mastery motivation ($p<.05$). Education level, repeat pregnancy, and self-reported depressive symptomatology did not significantly account for any of the mastery motivation variance. The quality of the home environment added significantly ($p<.05$), while intervention group membership marginally contributed ($p<.10$) to the prediction of toddler mastery motivation.

Although there is a modest association between test-taking motivation/behavior and test performance, they are differentially predicted on the basis of the variables under study (i.e., it was only the latter that reached true significance). One interpretation of these results is that mastery motivation reflects endogenous infant temperament characteristics (sociability, inhibition, activity level), rather than emerging aspects of competencies that are shaped by environmental experiences.

As hypothesized, the quality of the home environment accounted for a significant proportion of the variance for both toddler test performance and mastery motivation ($p.05$) whereas participation in a parenting support intervention contributed significantly to the prediction of test performance ($p.05$) and marginally so to the prediction of mastery motivation ($p<.10$). It may be that part of the effect of participating in the intervention is improved quality of the home environment, thereby reducing the intervention's effect in the regression analysis.

Does Prenatal Health Care Initiation Predict Maternal Depression among Urban Adolescent Mothers? Katherine Nitz

Presenter: Katherine Nitz

Studies indicate that adolescent mothers are at increased risk for depression and inadequate prenatal care. However, no studies have examined the link between initiation of prenatal care and subsequent maternal depression. A number of factors have been shown to increase the risk of depression, including a history of depression, increased stress, and inadequate social support. The relationship between prenatal care initiation and maternal depression, however, is important to determine since utilization of prenatal health care has been shown to lead to better maternal and child health outcomes.

The purpose of this study was to assess the differential impact of prenatal health care initiation, stress, social support, and previous depressive symptomatology on maternal depression among urban, adolescent mothers within a one-year postpartum period. Data were obtained from the Adolescent Health Care Evaluation Study, a one-year longitudinal study of 2,788 adolescents attending 1 of 10 urban adolescent health clinics throughout the nation. The study consisted of structured interviews conducted during two waves of data collection (Wave I: 1984-85 and Wave II: 1985-86), one year apart. For the current study a subsample of 424 adolescent females were selected based on the following criteria: 1) pregnant at Wave I; 2) gave birth by Wave II; and 3) did not give up baby for adoption or to foster care.

Adolescent mothers ranged in age from 13 to 18 years at Wave I and were never married. Almost 95% of the mothers were first-time mothers. Mothers were predominantly African American, low income, and from single-parent households. To assess depressive symptomatology, the Diagnostic Interview Schedule (DIS) was administered at Wave I and Wave II. To assess perceptions of social support, seven items indicating the degree to which adolescents felt they could rely on parents and peers for support were summed to create a total social support scale. To assess the presence/absence of stressful events, ten items were summed to create a total frequency of stressful events. Finally, prenatal health care initiation was defined as the month during the pregnancy in which prenatal care was initiated.

Results indicated that although relatively low levels of depression were found in this sample of adolescent mothers, moderate to high levels of stress were present. The mean initiation of prenatal care was three months. Stepwise multiple regression analysis was conducted to determine the impact of prenatal health care initiation, previous depressive symptomatology, stress, and social support on maternal depression. Results indicated that after controlling for sociodemographic variables, previous depressive symptomatology, more stress, less perceived social support, and later initiation of prenatal care were associated with increased maternal depression. Previous depressive symptomatology accounted for the greatest portion of variance, followed by stress at Wave II, social support at Wave II, and prenatal health care initiation. Results indicate that interventions should focus on providing mental health services as part of comprehensive prenatal care for adolescents.

Home Visiting Impacts Positively on Pregnant and Parenting Teens

Priscilla Lincoln, Andrea Battaglia

Presenters: Priscilla Lincoln, Andrea Battaglia

A multidisciplinary program, In Step, was developed in hopes of impacting positively on the lives of pregnant and parenting teenagers. The primary approach is public-health nurse home visiting combined with site-based prenatal and parenting groups and linkages for educational and vocational services provided by social workers and family support workers. Additionally, the program seeks to impact on the grandparents of the teens in order that their ability to provide support and guidance to the teens would be strengthened. The program seeks the following goals: positive pregnancy outcomes; enhanced child development outcomes; optimal pediatric primary care; development of parenting skills; prevention of repeat pregnancies; and positive involvement of fathers. Services include pregnancy counseling; prenatal, postpartum, and pediatric care coordinated with their Medical Providers; nutrition counseling and coordination with WIC; parenting support and education; sexuality awareness and health education; support and counseling for fathers; and support and counseling for grandparents.

Eighty-nine pregnant and parenting adolescents aged 13-18 years participated in the In Step Program, including 59 infants, 17 fathers, and 3 grandparents. Sixty-six percent of the teens were African American, 30% Latino, and 4% other. The average length of stay was 9.3 months; 44% remained in the program for 10 months or longer. (The intended length of stay was through the child's second birthday, and three teens had accomplished this by September 1995.) Medicaid was the primary insurance for 83% of the teens; 74% were in school upon entry into the program.

Data collected included demographic information, number of prenatal care visits with the medical provider, pregnancy outcomes and birth weights, immunizations and well-baby care, and school attendance. These data were collected upon intake, after delivery, and at 6, 12, and 24 months (or exit from the program) between January 1993 and September 1995 by the public health nurses and social worker. Additionally, public health nurses used the Ages and Stages Questionnaire to screen infants and toddlers for developmental delay, as well as to teach parents about child development. Data were collected during regularly scheduled visits.

A Chi-square test was used to assess differences between the program sample and the comparison samples. In Step teens had significantly earlier and comprehensive prenatal care than comparison teens ($p < .05$); more well-baby care and immunizations at 6 months and significantly more well-baby care and immunizations at 12 months than comparison teens ($p = .07$); and better birth outcomes, fewer repeat pregnancies, and lower school drop-out rates than comparison teens. Finally, In Step infants evidenced optimal development.

The facts, modest but compelling, that these often high-risk adolescents cared for themselves and their babies throughout pregnancy and after the birth of their babies and that their children are developing appropriately offers hope for ongoing success. Repeat pregnancy rates and school dropout rates are of concern and require the development of more creative intervention strategies.

Welfare Programs and Repeat Childbearing: Effects on Teenage Mothers and Their Preschool Children *Pamela A. Morris*

Paper not available

Applications from Research in Other Countries

How Does The Parent-Preschool Partnership Work? *Sharone L. Maital, Yael Gabrieli*

Presenter: Sharone L. Maital

The processes whereby parent involvement (PI) affects parents in early childhood settings are less clear than the outcomes for children. PI is multifaceted and may affect parents differently. Two models of parent partnership influences—an educational and an ecosystemic, family relations model—were used to evaluate the effects of parent participation in preschool. Educationally oriented approaches emphasize the benefits of continuity between home and school. Ideally, PI enables parents and teachers to establish consistent expectations. Ecosystems models emphasize family-like qualities of parent-school relations. Cohesion has been proposed as an important dimension of family-school relations.

The PI program of the Department for Parent and Community Education (PCE), Israel Ministry of Education has both educational and ecosystemic relations components. Both dimensions are included in teacher training and supervision. In the PCE program, parents, teachers, and children meet an average of seven times a year for various joint activities.

Middle-class parents ($N=114$) and teachers ($N=12$) from six kindergarten classes responded to questionnaire measures during spring parent-teacher meetings. Three classes participated in the PCE program, two classes had no PI program (three formal parent-teacher meetings), and one class had an informal PI program (six meetings, but these did not follow the PCE approach and the teacher had no special training). Parents were predominantly Israeli born and had at least 12 years of education. Responses were unrelated to socioeconomic differences or family size. All classes were taught by teachers with a senior teaching certificate.

Expectations were measured by ratings of developmental tasks. Perceptions of the family-like quality of relations were assessed by an adapting Olson's Family Adaptability and Cohesion Evaluation Scale (FACES) to refer to family-teacher relations, rather than relations among family members.

The lack of significant differences between parents and teachers on all measures is notable. Israeli middle-class parents and teachers appear mainly similar in their developmental goals and their perception of relations, regardless of PI. This is consistent with the Israeli context as a relatively small, communal society with a highly centralized educational system.

With respect to influences of PI, the results support the view that effects of PI can be meaningfully differentiated. The PCE program related to developmental expectations emphasized by an educational approach, but not to the family-like quality of relations. PCE program classes differed from other groups with respect to expectations for polite behavior, sharing, answering questions, reading from picture books, counting to 10, and use of scissors. Regardless of the PCE program, the number of meetings between parents and teachers and personal qualities of each teacher were important for ecosystemic relations. Observations of the lower cohesion PCE group suggested that the teacher was uncomfortable with PI. This illustrates the sensitivity of a family-relations measure for assessing qualitative aspects of parent-teacher relations.

Home Environment and Developmental Outcomes in Preschool Children in Jamaica

Janice S. Hayes

Paper not available

Delivering Child Care Services within the Social and Cultural Context of India: A Model Approach: ICDS *Beena Achhpal*

Presenter: Beena Achhpal

In India, the Integrated Child Development Services (ICDS) program is designed to serve a population similar to the Head Start population in the United States. This paper describes salient features of the ICDS program in terms of its philosophy, services, implementation approaches, and strategies. These may prove useful for replication within intervention models and programs for children and families in other sociocultural settings.

The ICDS model builds on a holistic and systemic perspective of human development. The ICDS scheme 1) offers several mutually supported services for both children and their families; 2) maintains high-level functional coordination and integration of services with other programs in the country, for maximum utilization of existing resources and services; and 3) maintains close functional linkages at the community level in performing its services with allied programs and agencies. The ICDS services are geared towards improving both the prenatal and postnatal environment and development of the child.

Besides services for children (0-6 years), other target groups include 1) pregnant and nursing mothers; 2) adolescent girls; and 3) disadvantaged women between 15-45 years. The services for children include health check ups, immunizations, supplementary nutrition, preschool education, and referral services. The services for mothers and adolescent girls include parent education and skill development, supplementary nutrition, health, immunization, and referral services.

Another significant strategy of the ICDS program is its community development approach. The ICDS services are implemented through a network of Anganwadis (a play center for children) located in rural, tribal, and urban slum areas. The key person for running and implementing the ICDS program at the Anganwadis is the Anganwadi worker (AWW), who usually is a local community woman. Selecting local women as agents of community development is one of the major strengths of this national program in the following terms: 1) the AWW is able to easily identify the needs and problems of the community; 2) the community can easily identify with this major agent of human resource development; and 3) the AWW is able to provide a critical link between the community and the administration in identifying and meeting the needs of the community.

To plan, implement, supervise, and coordinate the delivery of services from the project level to the grassroots level, the ICDS team consists of three levels of trained functionaries: 1) the Anganwadi workers; 2) the Supervisor (an intermediate-level functionary who supervises a number of AWWs); and 3) the Child Development Project Officer, who is overall in charge of the program at the project level. Functionaries at all levels of the scheme work in close coordination with functionaries in other government programs. For example, a high level of coordination is maintained between ICDS and the Maternal and Child Health Program. The Anganwadi workers provide the grassroots-level link with the Primary Health Centers. Extensive coordination between university programs and the ICDS scheme is maintained. The academic institutions provide low-cost training of the workers and objective feedback and program evaluation. The ICDS setting is used for field-level experiences for students. For continuous improvement and corrective actions within the ICDS model of services, implementation of the ICDS program is closely monitored. Reports are sent to the Planning Commission, NIPCEED, and other ministries and organizations in the ICDS program.

Time in Child Care: Predicting School Readiness at the Start of Kindergarten

Kate Christian

Presenter: Kate Christian

Reliance on some form of child care has increasingly become the norm among families with young children in the United States. Given the prevalence of children in care, a key question for researchers has been "What effect does child care have on children's development?" This study investigated the role of time spent in child care centers in predicting "school readiness" at the start of kindergarten as measured by academic achievement tests. Specifically, the total number of months spent in center-based child care prior to school was considered a unique predictor of early academic skills among two groups of children: children from mothers with a maternal education of 12 years or less ("Low-SES", $n=220$); and children from mothers with maternal education of more than 12 years ("High-SES", $n=269$).

Data was collected during the 1991-92 school year on 489 children entering kindergarten (mean age=5.4 years) in 16 elementary schools in North Carolina. The entire sample consisted of 50% Caucasian, 49% African American, and 1% of other ethnic backgrounds, and roughly equivalent percentages of males (49%) and females (51%). Background information about the families was obtained through parent questionnaires, and academic tests were administered during the fall of the kindergarten year, upon parental consent.

First, results showed that scores of low-SES children (based on maternal education) were significantly lower than those of higher SES children on all background measures and academic achievement tests ($p's < 0.5$). Second, more time in center care was associated with higher scores among all children. However, the unique variance predicated by total months in center care beyond child IQ, maternal education, and a measure of a child's family literacy environment was evident in mathematics (4.5%, $p < .05$), letter recognition (3.6%, $p < .05$), general information (1.2%, $p < .10$), and receptive vocabulary (1.2%, $p < .10$) among the lower SES sample of children only. No unique variance in academic measures was predicted by time in center care among the higher SES sample.

This study suggests that more time spent in child care centers has a positive impact on the academic/school readiness skills of children at the start of kindergarten. Further, the importance of spending time in care in explaining the individual differences in academic performance when children arrive at school was much greater among a group of low-SES children from homes of lower maternal education than it was among children from higher SES, more educated mothers. However, further research is needed to determine whether differences in academic skills would remain when considering indices of SES besides level of maternal education.

Results of the study have important policy implications. The findings suggest that time spent in child care centers is much more important for low-SES children. However, data on the background characteristics revealed that it was actually the higher SES children who spent more total months in care on average (high-SES $m=28.0$; low-SES $m=14.7$). This implies a discrepancy between which children are participating in center care for longer periods of time (higher SES) and which children appear to benefit the most academically from time spent in child care centers (low SES).

School-Age Care Contributes to the Maintenance of Aggressive Behaviors

Donna R. White

Presenter: Donna R. White

Several studies have reported that children with extensive preschool group experience are aggressive and noncompliant. Few studies have examined the effect of school-age care on behaviors such as compliance or aggression because most children who attend after-school care previously attended preschool groups, and it is difficult to separate preschool and school-age effects. In order to address the question of school-care contributions to negative behaviors, this study investigates social behavior of children attending school-age care and home care at the beginning and end of kindergarten.

Seventy-six kindergarten children participated in the study. Quality of care was minimal to good as rated on the School-Age Environment Rating Scale. Teachers rated children on aggression, likeability, withdrawal, compliance with adults, and rejection. Fifty random observations were taken on each child in the kindergarten classroom. Observations were coded as positive interactions; negative interactions such as hitting or grabbing toys; and positive or neutral solitary activities such as playing alone or watching other children. Parents rated their children's activity level, shyness, sociability and emotionality, and provided information on their educational level, the amount of time their child had spent in day care, and the child's current care arrangements.

Mean scores on teacher ratings, parent ratings, and observed behaviors in boys and girls attending school-age care or home care were compared. These comparisons showed that children in school-age care have extensive preschool group experience and enter kindergarten with significantly higher ratings on aggression, lower ratings on compliance, and more negative peer interactions than home-care children. These differences were still present at the end of the kindergarten year.

In order to determine whether after-school care independently predicted aggression, compliance, and negative interactions, hierarchical multiple regression analyses were used. At the beginning of kindergarten, each of the three measures was significantly predicted by being a boy, by parent ratings of high activity level, and by more time spent in preschool day care. At the end of the school year, after-school status added independent, significant variance to predictions of high aggression, low compliance, and greater negative interactions.

This study supports work indicating different behavioral styles in children with preschool group experience compared to home-reared children. It provides evidence that school-age group care may contribute to aggressive, noncompliant behavior patterns. It is noted that the quality of after-school care in this study was uniformly low. Different results might well be found if after-school care were of good to excellent quality.

While it is tempting to conclude that low-quality group experience contributes to aggressive or negative behaviors, the actual between-group differences are small. No differences were found on likeability ratings or positive interactions with peers. Future research needs to address the question of whether the more "aggressive" styles seen in school-age care children become problem behaviors or are related to independence and assertion as the child matures and learns new strategies for dealing with frustrating interpersonal situations.

Caregivers' Relationships with Mothers and Mothers' Satisfaction with Their Child Care Arrangements

Nancy Keefe, Nancy Mullin-Rindler, Carolee Fucigna

Presenter: Nancy Keefe

The subjects for this study were a subset of mothers, their children, and their children's caregivers providing 10 or more hours of non-maternal care each week. All were participants in the Massachusetts site of the NICHD Study of Early Child Care, a 10-site longitudinal study funded by the National Institute of Child Health and Human Development. For this poster, data were collected from the mothers and from their children's caregivers. There were 44 twenty-four-month-old children and 44 thirty-six-month-old children. Caregivers included center-based care, family day care, and other home-based caregivers. The sample size varies depending on the analysis. Each caregiver was asked to complete two different questionnaires. "The Parent and Me" is the caregiver's questionnaire, rating aspects of their relationship with the study child's mother. Each caregiver also completed two questionnaires assessing his/her child development knowledge of 24- and 36-month-olds: "Opinions About Two Year Olds" (24 items) and "Opinions About Young Children" (36 items). Mothers of the study children were asked close-ended questions about their satisfaction with their children's care arrangement.

There were no differences between the three types of care with regard to either the caregiver's rating of the mother/caregiver relationship or mother's satisfaction with the care arrangements. This was true at both the 24- and 36-month age points. At 24 months no difference was found in the level of caregiver knowledge by type of care, but at 36 months, center-based caregivers had a higher level of child development knowledge than did either the mother's partner or home-based caregivers. At 36 months there was a strong connection between the caregiver's child development knowledge and the caregiver's rating of his/her relationship with the mother. Home-based caregivers who had a higher level of child development knowledge also had a better quality relationship with the mother ($r=.55$, $p<.05$). For center-based caregivers, the correlation between the caregiver's child development knowledge and his/her relationship with the mother was not significant, although the trend was the same. There was no correlation at 24 months. Two variables were shown to be linked to mothers' satisfaction with their child care arrangements: 1) the relationship between the caregiver and mother; and 2) the level of the caregiver's child development knowledge. At 36 months, mothers were more likely to be completely satisfied with their child care arrangement when caregivers rated their relationship with the mothers more positively ($r=.32$, $p<.10$). We found no such connection at the 24-month age point. At 36 months, the mother's satisfaction was related to the caregiver's level of child development knowledge. Mothers were more satisfied with arrangements in which the caregiver scored higher on the rating of child development knowledge ($r=.36$, $p<.05$). No correlation was found at 24 months.

Describing Child Behavior and Child-Caregiver Interactions in Families at Risk*Jane Atwater, Rosanne Williams*

Presenters: Jane Atwater, Rosanne Williams

This poster presents research from the Early Childhood Research Institute on Substance Abuse, established to determine needs and develop interventions for children with prenatal exposure to alcohol or illegal drugs. Our conceptual model assumes that effects of prenatal exposure can best be understood by considering the interplay of multiple risk and protective factors that occur in a child's life. To examine multiple factors over time, ECRISA has conducted a longitudinal study of 287 children from three age cohorts: 1) infants (birth-24 months); 2) toddlers (18-42 months); and 3) preschoolers (36-60 months). Longitudinal data include developmental assessments, family measures, and direct observation of children's natural caregiving environments. This poster focuses on caregiver-child interactions assessed during typical activities in the child's home. Our purpose is to illustrate the use of observational data to determine how broad risk factors, such as poverty, might be translated into children's daily experiences at home and to identify natural caregiving experiences that appear to facilitate significant child behaviors.

Although our sample is diverse, most of the families face circumstances (e.g., poverty) identified as risk indicators in previous research, and our findings are consistent with previous studies in suggesting that the accumulation of multiple risk factors, rather than presence of a particular factor, is most predictive of developmental declines in early childhood. To examine the impact of accumulated risks, we compared caregiving interactions of exposed children with few environmental risks (0-1) to those of children with four or more risks. In families with greater risk, caregivers spent less time closely involved and talking to their children and were less likely to prompt and expand children's language. In turn, children had lower rates of developmentally advanced play and communication and spent more time not engaged in any activity. We emphasize, though, that risk indicators such as poverty do not lead inevitably to problems in caregiving and child development. Many caregivers, despite significant risks, supported their children's development in many ways. It seems plausible, though, that environmental risks create circumstances that make it more difficult for families to provide such support.

To discover how caregivers foster development, we examined natural sequences of child-caregiver interaction. With closer caregiver involvement, both toddlers and preschoolers were more likely to communicate, especially when the caregiver was sharing the child's activity rather than merely supervising. The probability of child communication increased most significantly following language prompts and expansions from the caregiver. These preliminary analyses indicate that effects of prenatal exposure cannot be understood adequately without considering environmental factors that may affect a child and family. In particular, greater risk appears to be related to caregiving that is less supportive of children's language. Thus, intervention studies are underway to increasing families' opportunities for shared activities and to teach caregivers to prompt and expand language. Also, a study has begun to follow children through grade three, permitting an analysis of the relationship of early experiences at home to later school adjustment and progress.

Preschoolers' Conceptions of Home versus Day Care: Rethinking the Structure of Children's Daily Lives *Anastasia Galanopoulos*

Presenter: Anastasia Galanopoulos

This study examined preschoolers' experiences of being at home and at day care, as well as their ability to think about their own development in each setting. Subjects were 22 children from two community-based preschool programs who were interviewed and completed rating and ranking tasks. Parents and teachers completed questionnaires on their beliefs about children's learning.

Children were able to provide coherent and consistent information about their own learning at home and at day care. Home was associated with learning about physical, intellectual, and language development. The trend for moral development and independence was also in the direction of home, but did not reach statistical significance. Day care was associated with learning about rules, sharing, and playing with friends. Academic preparation and talking about feelings were also perceived to be learned at day care, but differences were not significant.

Children reported an abundance of rules in their daily environments, but suggested that their experience of rules in the home versus their day care center was qualitatively different. Fifty percent more prohibitions were used at day care as compared to home, but there were just as many prescriptions in both settings. At home, children were given 75% more choices in what they were allowed to do, as compared to day care. Children also reported feeling more like a special individual at home, whereas at day care they tend to report feeling more like a member of the group. Parents disagreed with children's perceptions that home best fosters independence and intelligence. Teachers reported that day care provided the best environment for almost all aspects of preschoolers' development. Results and implications are discussed in relation to quality of care.

Providing Full-Day Services for Head Start Children *Sharon G. Deich, Lorelei Brush*

Presenters: Sharon G. Deich, Lorelei Brush

The last two decades have witnessed both a decline in funding for services for children and families and an increasing in family dysfunction. In this climate of increasing needs and decreasing dollars, programs have had to find ways to share scarce resources to provide needed services. One example of this type of collaboration is seen in the provision of full-day services by Head Start grantees. Although the traditional Head Start program operates for four to five hours a day, to better serve their children and families some Head Start grantees have developed programs to meet the need for longer hours of service.

This study examined the ways that full-day services are provided by a small group of grantees. It provides an in-depth look at eight grantees that fund extended hours by combining funding from a variety of sources. The goals for the study were to 1) document alternative approaches to providing full-day services; 2) identify the strengths and weaknesses of each approach; 3) describe the key policy issues that federal Head Start staff face in expanding to full-day service provision; and 4) clarify research questions regarding the provision of full-day services that should be considered for further evaluation.

Among the grantees, three distinct models of service provision were utilized. The paper describes each model, as well as its strengths and weaknesses. In addition, the paper discusses a series of issues that grantees had to deal with in pulling together multiple funding streams to provide full-day services for Head Start children. Some of these issues include developing new fiscal management strategies; covering funding short falls; developing policies to deal with parental loss of eligibility for non-Head Start funds; and insuring quality services throughout the day. The paper concludes with a series of policy issues that the federal office should address that would support the expansion of full-day services by combining multiple funding sources.

The Long-Term Impact of a "Relationship-Centered" Child Care Program on Public School Performance and Antisocial Behavior *Charles H. Mindel*

Paper not available

The Use of Transitional Child Care: Analysis and Recommendations for New York City's Program *Laura Peck, Gabrielle Gerhard, Nancy Fox*

Presenters: Laura Peck, Gabrielle Gerhard

This study, commissioned by the Human Resources Administration's Office of Employment Services' Work Related Benefits Unit, examined the Unit's Transitional Child Care program in New York City. The purpose was to learn about forces that keep New York City's application rate for Transitional Child Care (TCC) near 20%, and how this application rate could be increased. TCC offers one year of financial support to cover child care expenses for families who leave AFDC for work, as mandated under the 1988 Family Support Act. The study consisted of three parts: 1) an examination of the Income Support AFDC case closing process; 2) a study of the TCC application response rate; and 3) a comparative policy analysis. Through structured interviews, we found that HRA's Income Support staff were unclear about features and benefits of TCC. The population leaving welfare for work in New York City was analyzed through a random sampling of administrative data on families leaving AFDC for work in two months of 1994. We found that applicants and nonapplicants for TCC were similar, with some exceptions.

Questionnaires were sent to 110 former AFDC recipients in New York City, both TCC applicants and nonapplicants. Thirty percent responded, and the average income of survey respondents was \$933.14 per month. Each week, case heads worked an average of 32.1 hours, and paid an average of \$68.76 for child care. The questionnaire also solicited opinions about experiences with HRA and the TCC programs. Recipients of TCC were generally positive about the program, stating that the program's support enabled them to stay employed.

By researching other state, county, and municipal TCC programs, we learned how some agencies have successfully increased participation rates by instituting service and marketing innovations. Some of these innovations were shortening or eliminating the TCC application form; encouraging caseworkers to promote program use; and informing clients about the program's features and benefits.

Our recommendations build on HRA's existing structures and procedures in four areas. First, we suggest refining administrative processes through simplification of the application, improvement in the distribution of the application, earlier approval of applications, and the streamlining of the service delivery system. Second, we recommend increased internal marketing efforts, including the insurance that Income Support staff are knowledgeable about TCC. Third, external marketing suggestions include making better use of existing informational flyers, distributing information on TCC to AFDC clients at first recertification, and developing workshops to educate clients about benefits available in the transition from AFDC to work. Finally, we suggest additional training for Income Support staff.

Most of the study's suggestions for increasing the application rate are reasonable, given ongoing resource limitations. Implementing some of these changes would advance the ability of the TCC program to help families seeking financial independence.

The Social Context of Teacher-Child Relationships in Rural and Small Town Child Care Centers *Maureen A. Sullivan*

Presenter: Maureen A. Sullivan

Investigations into the social context of center-based care on children's intellectual and socioemotional development have uncovered some disquieting results. Although research indicates positive outcomes for low-income children participating in high-quality, university-based programs, a recent study demonstrated that low- and middle-income children in community-based child care programs receive the poorest quality of care.

Whereas research into the determinants of parenting behavior has revealed the importance of the interpersonal environment, little empirical data exists that explores the social context of teacher-child interactions. This study examines factors in the interpersonal environment of child care teachers in a rural environment, including job satisfaction and a supportive social network, that have been linked to sensitive, involved, and responsive parenting. Consideration of the interpersonal environment may be especially salient when considering the stressors inherent in the child care profession.

To date, 17 preschool teachers from rural, community child care centers completed questionnaires assessing their interpersonal environment, including job satisfaction, the director's leadership qualities, and social support. In addition, teachers were observed on two separate occasions for a total of 80 minutes. The Arnett Scale of Caregiver Interaction was used to assess levels of teacher sensitivity, harshness, and detachment. Generally, teachers rated their level of satisfaction with their social network, their job, and their director's leadership qualities as very high. A ceiling effect was observed on the measure of social support. Teachers' pay was an area of discontent.

A disturbing trend was identified in teacher interaction style. When compared with teachers from centers primarily serving lower, middle, or upper income children found in a national sample by Phillips, et. al., this sample of rural teachers had fewer positive interactions in that they were less sensitive, more harsh and punitive, and more detached in relating with children in their classrooms.

This study demonstrates that conducting research in rural child care settings presents a unique set of challenges and issues. The response set encountered in questionnaire data may result from a general mistrust of research, the need to be seen by others in a positive light, and the fear that confidentiality would be breached. The findings that caregivers in this sample utilized lower levels of sensitivity and higher levels of harshness and detachment than a national sample is very interesting in view of the number of teachers in the present sample who hold four-year college degrees (41%). Although the percentage of college graduates in the national sample is substantially lower (22%), and previous research indicates that higher levels of education are associated with higher quality child care, just the opposite seems to be occurring in the current sample. Clearly, the importance of this study lies in its findings regarding the unique characteristics of rural child care. Further investigation into the broader social context of child care, especially in rural settings, is needed to inform policy and training efforts.

Do Employees Benefit from On-Site Employer-Sponsored Day Care?

Linda Lemesurier, Ellen V. Jacobs, Miranda D'Amico, Laurie Hellstrom

Presenters: Linda Lemesurier, Ellen V. Jacobs, Miranda D'Amico, Laurie Hellstrom

Combining work and family responsibilities is a situation many families deal with daily. Women are exposed to the same physical and psychological stresses in the work environment as men, yet they have the added stress of trying to assume multiple roles, which may include employee, parent, spouse, and homemaker. The demands of child rearing, particularly the problems associated with finding satisfactory child care arrangements, are a source of stress and guilt for working women, because much of this responsibility falls upon them. The trend for mothers of young children to enter the work force has created an intense demand for suitable child care. Major corporations and health care organizations have responded by providing child care services. Many features of on-site, employer-sponsored child care (OSES CC), particularly the accessibility and proximity of the children to their mothers, is believed to reduce levels of maternal stress and guilt for employed mothers.

This study explored maternal stress and guilt in employed mothers whose children were enrolled in OSES CC, versus those whose children were enrolled in a nonprofit community-based child care (NPCBCC). Thirty-six mothers from 5 OSES CC (17 boys and 19 girls) and 36 mothers from 5 NPCBCC (20 boys and 16 girls) participated in the study. The mean age of the children was 40 months, and all had been enrolled in the same day care center for at least 12 months prior to the study. The quality of the day care centers was assessed using the Early Childhood Environment Rating Scale. Demographic information was obtained through a telephone interview. The Hollingshead Four Factor Index of Social Status was used to calculate socioeconomic status. The Parenting Stress Index (PSI) was used to measure stress. The Maternal Guilt Scale assessed guilt related to the child's enrollment in day care. A home interview resulted in information about the current day care arrangement.

There were no differences between the two types of day care settings and levels of maternal stress or guilt. An analysis of variance indicated that there was a significant main effect on the PSI for sex, $F(2, 72) = .008$ $p < .01$. The mean PSI score for mothers of boys, regardless of care status, was 229.58, with a range of 166 to 291 ($N=33$), and the mean PSI score for mothers of girls was 208.97, with a range of 153 to 259 ($N=31$). The findings of this study do not support the commonly held notions about the advantages of OSES CC over NPCBCC. There were no differences in the levels of stress or guilt reported by mothers with children in OSES CC versus NPCBCC. Perhaps the benefits of on-site care are more evident for parents of younger children enrolled in day care and for those whose children are newly enrolled.

Child Care for Low-Income Families: What Is the Potential for Change under Block Grants?

Sandra Clark, Sharon K. Long

Paper not available

The Role of Caregiver-Child Microregulation in the Externalizing Behavior of Head Start Children

Ebenezer A.F. de Oliveira, Brian P. Ackerman, Carroll E. Izard

Presenter: Ebenezer A.F. de Oliveira

Parents and preschool teachers often have to deal with children's Externalizing Behavior (EXTB), including fighting, attention-seeking, and defiance. This study takes a person-process-context approach to explain EXTB in children from low-income families, after controlling for commonly-reported intrachild (Gender, Verbal Ability, and Negative Mood) and intracaregiver (Depression) correlates. Our major goal was to determine how daily, momentary interactions (i.e., microregulations) between the child and his/her caregiver contribute to EXTB.

The microregulatory variables were Caregiver's Directives (C-DIR), Caregiver's Verbal Response to Child Failure (C-VRF), and Dyadic Cooperation (DC). These variables were assessed through systematic observations of a videorecorded frustrating task involving 61 Head Start children and their primary caregivers. The task was to use plastic slates to build a house that resembled a model. Because the base that anchored the slates was missing, the task was very difficult. The task had four, 2.5-minute phases. In phase I, the child worked alone; in phase II, the caregiver provided verbal assistance; in phase III, the caregiver worked with the child; in phase IV, the missing base was provided and the child successfully completed the task.

C-DIR was the frequency of directives by the caregiver in phase II. C-VRF was the valence and intensity of the first caregiver utterance after the child failed on the task (i.e., dropped a slate) for the first time in phase II. C-VRF was measured through a 6-point Likert scale (1=strongly criticizes, ridicules—e.g., "Can't you keep those blocks up?" 6=laughs or sounds very excited about the task—e.g., "Oh boy, this is gonna be fun!"). DC was assessed through a five-second interval coding of phase III, involving the number of intervals in which the caregiver and the child held each a slate, so that the slates were contiguous.

Interobserver reliability on C-DIR, C-VRF, and DC was $r = .98, .97$, and $.96$, respectively. A block-entry, multiple regression analysis showed that the intrachild variables entered first explained EXTB, $F(3, 57) = 9.58, p < .001; R^2 = .34$. Caregiver Depression entered second significantly added to the variance in EXTB, $F(1, 56) = 11.22, p < .01; R^2 = .45$. Likewise, the R^2 increment for the microregulatory block entered third ($R^2 = .68$) was significant, $F(3, 53) = 12.77, p < .001$.

These results suggest that models including intracaregiver and caregiver-child microregulations can explain EXTB significantly better than organismic models that include only intrachild variables. As predicted, in the full model, EXTB correlated positively with Negative Mood and Caregiver Depression, and negatively with Verbal Ability and DC. However, the correlation between Verbal Ability and EXTB was only significant after C-VRF was entered in the regression equation, thus suggesting a suppressor effect. Against our predictions, C-VRF correlated positively with EXTB, and there was no significant effect either for GENDER or for C-DIR. The contribution of low DC to EXTB is consistent with previous transactional research. The role of C-VRF is intriguing. Our results suggest that the more positive response to child failure facilitates EXTB, whereas the more negative response to child failure curbs EXTB. This might be due to the poor contingency or subtle messages in the C-VRF of our sample.

Exploring the Relationship between Hyperactivity and Prereading Skills: Surprising Results with Low-Income Preschoolers

Olivia C. Nania

Presenter: Olivia C. Nania

A strong association has been established between externalizing behavior problems and poor reading achievement in children. Longitudinal studies indicate that children with behavior problems in preschool and early elementary school experience great reading difficulties during and beyond elementary school more often than peers without such behavior problems. While a relationship between early attention/behavior problems and later reading difficulties is certain, the exact nature of the relationship is not. Preschool behavior problems may simply predict later behavior problems, which in turn are associated with problems in reading at that time. But preschool behavior problems may also be associated with lack of preschool skills that are related to later reading achievement.

Preschool inattention/hyperactivity may affect development of preliteracy skills (e.g., awareness of letters, sounds, concepts of print, rhyming), which are important precursors of later reading success. The purpose of this study was to examine this relationship in kindergartners who had attended Head Start programs.

The primary participants were 154 kindergartners, originally obtained from four Head Start centers on Long Island, NY. In the spring of the 1994-95 school year, the children's preliteracy skills and verbal abilities were assessed. The primary kindergarten teachers of the children completed a shortened version of the Conners Teacher Rating Scale (the hyperactivity index), which reflects the child's level of overactivity and inattention. To explore the relationship between hyperactivity and reading skills, we created a simplified structural equation model for the data. We hypothesized that the children's verbal ability and hyperactivity ratings affect their prereading skills in kindergarten. We included verbal ability in this model because it has been shown to be highly related to prereading ability. This model is simplified because it, undoubtedly, does not contain all possible variables that might influence a child's prereading skills.

The causal analysis was run using EQS, a structural equation modeling program by Bentler. The normed fit index of the model was extremely high, .985, and the Chi-square was nonsignificant, indicating good fit of the model to the data. The beta weight for the path from the child's verbal ability to his/her emergent reading was .591, which is significant. However, the path from hyperactivity to emergent reading ($-.089$) was nonsignificant, indicating that the kindergartners' levels of overactivity and inattention did not significantly affect their prereading abilities.

Prereading skills and preschool inattention/hyperactivity were not significantly related in this low-income sample. One possible explanation for this lack of relationship is that learning prereading skills does not require a lot of attention and on-task behavior. Another, however, is that the kindergarten teachers in this sample were not focusing on prereading skills in the classroom.

The Impact of Significant Life Events on Children During Their First Three Years of School *Karen Taylor*

Presenter: Karen Taylor

Presented here is preliminary information on the connection between significant life events that children and families face and the impact of those events on children's educational outcomes. Data discussed are based on a sample of 209 families in Chapel Hill, North Carolina, whose children began kindergarten in 1992, 1993, or 1994. These children and families are participating in the Head Start Transition Demonstration Project. As part of a family interview, parents are asked 15 questions about events that have occurred in their lives in the past 12 months. The questionnaire is styled somewhat like the Sarason, et al. Life Event Scale, but it is not as comprehensive. Parents are asked the same questions annually for four years.

A summary of the data shows that families in the Transition Project have an average of 2.55 events per year. The most frequently occurring events are change in employment (33%), death in the close family (29%), gaining a new family member (22%), and separation of the parent and her/his partner (26%). Many families have experienced serious illness (22%) or have a close family member in jail (13%).

Pearson Correlations show interesting initial results. There is a significant negative relationship between the total number of life events a child experiences and his/her achievement scores. Children who experience more major life events achieve less in school. The fact that the relationship is significant for all four Subtests of the Woodcock-Johnson Tests of Achievement and the Peabody Picture Vocabulary Test strengthens this finding, although the analysis will not be complete until all of the information has been added to the database. Contrary to some of the literature on life events, correlations between total number of life events and social skills factors (cooperation, assertiveness, responsibility, or self control) or days absent from school did not show significant relationships.

There is also a positive, moderately weak relationship ($r = .235$, $p = .0035$) between the number of events that a family has at the initial interview and the number of events that a family has at follow-up. Families that experience more major life events are likely to continue to experience more events than families who do not experience many major events. If this trend holds true for a family over time, and if the child's academic outcomes are affected by the number of major life events that he/she faces, then the child's chances of good long-term educational outcomes may be at risk. Also, those families who have very serious negative events continue to have very serious negative events. There is also a significant positive moderate relationship ($r = .24$, $p < .0001$) between the number of events the family experiences and the parents' description of their frequency of depression. Parents who experience more events say that they are more frequently depressed.

Relations among Life Stressors, Body Image, and Cognitive Functioning in African-American and Latino Kindergarten Children: Implications for Early Detection and Prevention *Sebastiano Santostefano, Susan R. Santostefano*

Paper not available

Attachment Security with Mother and with Preschool Teacher: Relations to Behavior in Preschool *Elizabeth DeMulder, Jennifer Mitchell-Copeland, Susanne Denham, Michelle Stroppolo* Presenters: Elizabeth DeMulder, Michelle Stroppolo

Attachment theory proposes that early attachment relationships are fundamental influences on a child's socioemotional development. In order to advance our understanding of the processes involved, research must take into account interactive influences and the multiple contexts in which children develop. Relationships with nonparental caregivers may have significant influences, particularly under high-risk conditions.

This study investigates preschoolers' attachment security with mother and with preschool teacher, and links to child behavior and popularity with peers in preschool. As part of a large longitudinal study of social and emotional processes in development, 53 preschool-age children (26 boys, 27 girls) were observed at home with their mothers and in preschool with their preschool teachers in order to assess the child's attachment security with each caregiver. Different observers completed the Attachment Q-Set separately for each caregiver after final visits to home or preschool. Preschool teachers were asked to complete a questionnaire concerning the child's behavior with peers in preschool. A sociometric measure was used to assess peer perceptions of the child.

Analyses revealed a significant relation between attachment security with mother and with teacher for boys (but not for girls), suggesting that, for boys, the quality of the attachment relationship with mother may "set the stage" for subsequent attachment behavior patterns in relation to teacher. Regression analyses indicated that a significant amount of the variability in peer-reported likability and in angry/aggressive behavior was accounted for by attachment security with mother. However, the relation between attachment security with mother and angry/aggressive behavior was mediated by attachment security with teacher. In addition, a significant amount of variability in socially competent behavior and in anxiousness was accounted for only by attachment security with teacher. ANOVAs using categorical attachment classifications revealed that children who had insecure attachment relationships with both mother and teacher were the most angry/aggressive in preschool, as reported by teachers. Children who were securely attached to both mother and teacher were more socially competent than were children who were securely attached to mother but not to teacher. Evidence suggests that attachment security with mother and with teacher in the preschool period relates in theoretically meaningful ways to behavior with peers in preschool.

Results emphasize the critical need for preschool environments in which teachers are sensitive and emotionally available and children feel safe and secure.

Behavior Problem Development among Children at Risk for Alcoholism

C. Raymond Bingham, Hiram E. Fitzgerald, Robert A. Zucker

Presenter: C. Raymond Bingham, Robert A. Zucker

The research presented here compared patterns of problem behavior development among children growing up in three types of families: 1) families with a father who was alcoholic and antisocial (AALs); 2) families with a father who was alcoholic but not antisocial (NAALs); and 3) control families, in which neither parent was alcoholic or antisocial.

Theory and literature suggest that, by predisposing children to the development of antisocial behavior during adolescence and adulthood, behavioral maladjustment (e.g., aggressive behavior) during childhood plays an important role in the etiology of alcoholism. Antisociality is a known concomitant of alcoholism. Thus, childhood behavior problems may be part of a sequence leading from behavioral maladjustment during middle and late childhood to the development of antisociality in adolescence and alcoholism in adulthood.

This research examined developmental continuity and change in the association between paternal alcoholism and child behavior problems. It was hypothesized that 1) the children of alcoholics (COAs) would exhibit more behavior problems than the children of non-alcoholics; 2) those children whose fathers' alcoholism was comorbid with antisociality would have the highest levels of behavior problems; and 3) this pattern of group differences would persist longitudinally.

A three-risk-group repeated measures analysis of variance with time of measurement as the repeated within-subject factor was used to test the hypotheses. Analyses yielded three general results. First, problem behavior for children in all three risk groups decreased significantly. This is especially evident in total behavior problems, which decreased by approximately 50% over all three risk groups. Second, in spite of the decrease in behavior problems, significant difference between risk groups was generally maintained, with the children of AALs consistently demonstrating the most behavior problems. Third, the pattern of group differences changed slightly over time, typically resulting from significant differences between NAALs and controls at the first time of measurement becoming nonsignificant by the second.

The results of this research support extant literature and theory suggesting that COAs experience elevated levels of childhood problem behaviors. This research provides additional information suggesting that the children of alcoholic fathers with comorbid antisociality are at greatest developmental risk. Over time, the children of NAALs tended to show compensatory decreases in behavior problems, which resulted in fewer differences between control children and the children of NAALs. This result may be due to two influences: 1) the risk experienced by COAs may depend on the degree of comorbidity associated with their fathers' alcoholism; hence, the children of AALs would show the greatest risk; 2) the amount of paternal alcohol consumption may have decreased for NAALs, but not AALs, thus, decreasing the behavior problems exhibited by the children of NAALs. Future research will examine factors accounting for longitudinal changes in the risk experienced by COAs.

Caregiving Contexts and the Development of Prenatally Drug-Exposed Children

Brenda P. Jones

Presenter: Brenda P. Jones

There is a plethora of evidence that exposure to drugs in utero leads to compromised but variable child development outcomes. The contribution of the caregiving environment to variability in outcome has received limited research attention. This investigation explores the influence of different caregiving contexts on the development of children prenatally exposed to drugs. Using a three-group design, the study compared in-utero drug-exposed children reared in three settings: biological families, foster families, and congregate care facilities.

One hundred twenty prenatally drug-exposed children (40 per group) were identified through birth records that indicated positive drug toxicologies. All the children were African American, AFDC eligible, and between 9 and 36 months. Children in group care were significantly younger than those in family contexts. Gestational age and gender were equivalent across groups. Children with major neurological and/or physical health impairments were excluded.

Child development variables were measured via the Bayley Scales of Infant Development, the Child Behavior Checklist, and the Vineland Adaptive Behavior Scales. Ecological variables were measured with the Beck Depression Inventory, the Parenting Stress Index, the Family Adaptability and Cohesion Scale, the Family Support Scale, the Family Resource Scale, the Child Rearing Practices Report, the Home Observation for the Measurement of the Environment Scale, and the Infant/Toddler Environment Rating. The assessments were conducted during a clinic visit and home visit with each child/caregiver dyad by two researchers. Infant assessments were conducted in the clinic by a researcher blind to rearing group. Home assessments were conducted by researchers with no knowledge of the study hypotheses.

Due to the age confound, children under two years were compared with those over two. ANOVA procedures revealed that children under two had higher mental development quotients ($p < .04$), higher adaptive behavior scores ($p < .001$), fewer behavior problems ($p < .06$), better social orientation ($p < .005$), better emotional regulation ($p < .001$), and higher quality of motor skill ($p < .001$) than children over two. Separate between-group analyses, using ANOVA, were conducted within these two age groups. No differences were found between rearing groups for children over two. For children under two, group-reared children had poorer emotion regulation ($p < .001$) and motor skill quality ($p < .001$) than children reared in family contexts. Group caregivers reported fewer child behavior problems than foster parents did ($p < .03$). There was a trend toward group-reared children having lower mental ($p < .10$) and motor development ($p < .09$) quotients. There were no group differences between children in biological and foster-family environments.

Evidence from this study suggests that the social ecologies of drug-exposed children do influence their development. The effect of the environment seems to be strongest when the children are younger. Group care environments appear to be more deleterious to child development. The lack of differences between children reared in biological and foster families suggests that being reared in family settings may be more important than the individual characteristics of the family. Additionally, the biological family constellations may include another family member who provides the child what the parent cannot. Future research should include more observation of child behavior within different caregiving contexts.

Social Involvement with Peers and Teachers as a Function of Type and Severity of Mainstreamed Preschoolers' Disabilities

Lawrence V. Harper, Karen McCluskey

Presenter: Lawrence V. Harper

We analyzed one to five (mode 4) 20-minute videotapes of each of 16 mainstreamed, special-needs children's behavior during free play in two University Laboratory preschool sessions with adult-child ratios of at least 1:5. Both sessions enrolled 4-6 special-needs children and 20-24 normally developing youngsters each year. We compared these tapes to similar tapes of 16 normally developing children matched for age (within one month), gender, and session. Among the special-needs subjects, three were motorically impaired (two females and one male with cerebral palsy severe enough to confine them to wheelchairs); five children had severe language impairments (one male diagnosed as autistic, one male with cerebral palsy, one male and two females with Down's Syndrome); eight children had "mild" developmental delays (two males and one female with mild speech/language delay, one male with "delayed motor planning," and two males and two females with Down's Syndrome). Videotapes were coded for subject's location, social context, activity, and degree of social participation. Entries were made whenever there was a change in any category; the time and initiator of each change was also recorded. Kappas for all categories ranged from .7- .8.

Analyses of behavioral sequences indicated that adults were significantly more likely to interact with a special-needs child than a control child when the subject was engaged in self-initiated solitary activity ($p < .001$, Fisher's exact test). ANOVAs revealed that the three motorically impaired children spent significantly ($p < .05$) greater proportions of time with adults than controls and self-initiated proportionately fewer activity changes than any other group ($ps < .05$); correspondingly, in comparison to all other groups, save the language impaired, a significantly ($ps < .05$) greater proportion of the motorically impaired children's activity changes were adult initiated. Despite the fact that the language-impaired children had significantly higher rates of contact with adults than the controls ($p < .05$), they spent proportionately more time in solitary activity than any other group ($ps < .05$) and less time in groups containing both adults and children than did controls ($p < .05$).

In comparison to the controls, for significantly greater proportions of both the motorically impaired and the language-impaired subjects ($ps < .05$), adult-initiated breaks in interaction were more likely to be followed by another bout of adult-initiated interaction. In adult-child groups, for all three of the motorically-impaired but none of the controls, ($p < .001$), a peer-initiated exchange was the most probable event to follow an adult-initiated exchange involving peers. Adult response did vary according to the nature of the child's disability. The relative isolation of the language-impaired children seemed to be partially explained by their inability to respond to social overtures. Even with an abundance of caregivers, language-impaired children seem to be especially at risk for social isolation.

Children with Special Needs

A Collaborative Services Approach to Including Children with Special Needs in Head Start Classrooms

Mary Beth Bruder, T. Diane Hatcher, Ilene Staff

Presenter: T. Diane Hatcher

Recently, a consensus among educators and child care providers has been developing that the relationship between early childhood special education and early childhood programs should be redefined. This has been supported by a growing research literature on the educational benefits of including children with disabilities within programs for children who are developing more typically. The inclusion of children with special needs is not new to Head Start. Since 1972, the organizational policy has been that children with special needs comprise at least 10% of all the children enrolled.

As part of a larger five-year demonstration project awarded to the University of Connecticut Department of Pediatrics, the Collaborative Services Project's purpose was to develop, implement, and evaluate a model of collaborative early childhood services for young children with disabilities and their families within Hartford, CT. Following are highlights from the Head Start component.

A program of inservice staff development training based on principles of adult learning and oriented toward practice was presented to 82 teachers, aides, and administrative personnel. The training on topics such as developmentally appropriate practice, behavior management, team work, social competency, attention deficit disorder, and play and play interventions, emphasized a hands-on approach and always related to the teachers' desire to meet the needs of all the children in their classrooms. Project team members worked with Head Start Administration to identify children with special needs. The team responded to any requests from teachers for assessments of individual children or assistance with classroom planning to meet the children's and teachers' individual needs.

The program is being evaluated using a variety of both formative and summative measures. Analysis of participants' evaluation of the training sessions indicated (using a 5-point Likert scale) that 80% or more agreed with positive statements concerning objectives, relevancy, organization, increased understanding, and preparation; more than 50% strongly agreed with each of the positive statements.

Head Start participants had favorable attitudes toward the concept of inclusion. All participants identified at least 10 of the 14 as probable or definite benefits and identified at least twice as many benefits as concerns. After year three all participants identified all 14 of the benefits as probable definites, and there was a statistically significant decrease in the number of concerns to inclusion identified as probable or definite concerns. There were some indications of concern; every participant responding agreed with at least two concerns and half agreed with seven or more.

In addition to the quantitative measures, in-depth interviews with teachers and administrators, focus groups, and classroom observation were used to provide data of the investigation of a contemporary phenomenon within its real life context. The case study interviews focused on questions of "how" and "why".

Collaborative models of service delivery are optimum for children with disabilities and their families. Unfortunately, the development and implementation of such models remain an elusive goal for many communities. Head Start can provide the foundation for collaborative models as the Head Start philosophy embraces a holistic approach to a diverse group of families and children. Preliminary efforts in Hartford, CT, to build a collaborative service-delivery model for children with disabilities have proven successful within Head Start.

Correlates of Children's Interactions with Classmates with Disabilities in Inclusive Classrooms

Linda Hestenes, Susan Kontos, Lynn Okagaki, Karen Diamond

Presenters: Karen Diamond, Susan Kontos

Although including children with developmental disabilities has been a mandate for Head Start programs, little is known about how experience in an inclusive classroom affects young children's development. Parents and teachers believe that inclusive programs provide children with opportunities for developing prosocial behaviors and accepting diversity in others. It seems reasonable to presume that for these opportunities to be realized, children with and without disabilities must interact with some regularity. We know very little, however, about children's actual experiences in inclusive classrooms.

The present study was designed to shed light on whether the frequency of children's interactions with classmates with disabilities is related to 1) their understanding of the capabilities of hypothetical children with disabilities; 2) their expressed willingness to play with hypothetical children with disabilities; and 3) their parents' beliefs about children with disabilities.

The sample consisted of 53 children (21 boys, 32 girls; mean age = 57.6 months) attending one of two inclusive, university-based early childhood programs. Ten to 15% of the children in each of the six classrooms had identified disabilities; 40 mothers and 34 fathers completed parent questionnaires. Measures included a children's interview that included Harter-type items to assess children's understanding of competencies (motor and language), social acceptance for hypothetical children with and without disabilities, and open-ended interview questions that were coded to reflect children's expressed willingness to play with hypothetical children with and without disabilities. Measures also included observations of children's behaviors, including the frequency of children's social play with classmates with and without disabilities using a 2-second look, 13-second record scanning technique, and 50 observations per child distributed across at least two weeks. Mothers and fathers individually completed a short questionnaire designed to assess 1) the approaches they would take in social situations involving a child with a disability; and 2) expectations they have for their children's prosocial behaviors.

In this study, we found that both children's expressed willingness to play with children with disabilities and their parents' belief in going out of their way to interact with children with disabilities were positively associated with frequency of children's interactions with children with disabilities in free-play situations. However, parents' general prosocial expectations for their children were not related to their children's actual time spent playing with children with disabilities.

These results suggest first that there is a relation between what children say they believe and what they actually do. Second, the relation between parents' specific ideas about their own involvement with children with disabilities and children's interactions with classmates with disabilities is consistent with the hypothesis that young children's behaviors toward peers with disabilities are likely to be influenced by what adults model rather than by what adults teach or verbally encourage. Third, the lack of relation between parents' general prosocial expectations and children's behaviors toward classmates with disabilities may not be surprising. Mothers' beliefs about the importance of prosocial behaviors, such as those described in our questionnaire, were unrelated to their specific behaviors, or to their children's behaviors, unless their children's were maladaptive. Our finding of no relation between parents' social beliefs and children's social behavior is consistent with these results.

Children with Special Needs

The Comparative Outcomes of Two Treatment Approaches for Children with Communication Disorders in Head Start

Felicia M. Valdez, Judy K. Montgomery

Presenters: Felicia M. Valdez, Judy K. Montgomery

This study was designed to address the paucity of empirical data regarding the efficacy of treatment approaches for preschool children with communication disorders. Specifically, this study examined the differences in the effectiveness between the inclusion model of speech/language treatment and the traditional pull-out model of speech/language treatment. African-American children in an inner-city Head Start program with documented speech/language delays were randomly assigned to groups using the two treatment approaches. Results supported the research hypothesis that there is no significant difference between these two models of speech/language treatment. Findings suggest that the inclusion model is just as effective as a traditional pull-out model in conducting speech/language services for children with mild, moderate, and severe communication disorders.

Integrating Mental Health and Early Intervention for Children and Families Affected by Alcohol and Other Drugs

M. Susan Burns, Vaughan Stagg

Presenters: M. Susan Burns, Vaughan Stagg

The goal of our program was to address the varied needs (i.e., daycare, prevention services, early intervention) of families with infants and toddlers who reside in a public housing community. The goals the program presented in this paper are 1) to prevent infants and toddlers from developing psychiatric problems; 2) to enhance development; 3) to support parents in parenting and obtaining treatment when necessary; and 4) to permit parents to stay in or enter the work force. We provided developmentally appropriate, emotionally supportive, and developmentally inclusive services for infants and toddlers. The Partners for Learning Curriculum was used. Family services and interagency coordination services were integral parts of the program.

In evaluating this program, our children with special needs were compared to typical children who completed this same program. We found that our intervention was effective in helping children reach criterion in the areas of cognitive, social, and motor development, although in the cognitive and social areas the typical children tended to have higher achievement than children with special needs. Progress was closely related to the amount of intervention received. We were not effective in providing effective intervention in the area of language development, although 34% of our infants received speech therapy as an ancillary service (typical = 17%; special needs = 47%). There remained a higher incidence of mental health problems in our special-needs children at follow-up than with our typical children. Parents who needed drug and alcohol treatment and received it were more likely to participate in the parent components of our program. These tended to be those of children who entered the program before their first birthday and for whom the intervention was most effective.

Overall, these findings are positive when the children and their families participate in and complete the program. One must keep in mind, however, that a number of our children with special needs (27%) did not complete the program because of family instability, and half of these children were placed in Child Protective Services.

Normative Sexual Behavior in Children with Disabilities

Trudi Venters Horton, Karen K. Lozano, Bridget O. Hannahan, Shirley L. Robinson

Presenters: Trudi Venters Horton, Karen K. Lozano, Bridget O. Hannahan, Shirley L. Robinson

This study provides preliminary descriptive data from the Child Sexual Behavior Inventory Version 3 (CSBI-3) on the frequency and range of sexualized behaviors in prepubertal children with suspected developmental delays. Such children were typically excluded from past research using three versions of the CSBI. Initial normative sampling for the CSBI and the CSBI-R primarily included White children without disabilities from middle- to upper income families. Additional work demonstrated the utility of the CSBI in discriminating higher levels of sexual behavior in sexually abused children compared to nonsexually abused children (either with or without psychiatric disturbances) in similar samples.

In Phase One of this study, 52 female caregivers of 2- to 10-year-old children with suspected or confirmed neurodevelopmental disabilities completed the CSBI-3 and an age-appropriate version of the Child Behavior Checklist (CBCL). Subjects were recruited upon presentation to the child's outpatient neurodevelopmental evaluation at interdisciplinary clinic(s) within a medical school's university-affiliated program in a large southern city. All responses remained anonymous. Phase Two of the study is currently in progress, with data being collected from female caretakers of an additional 50-75 children referred for neurodevelopmental evaluation. In addition to the CSBI-3 and the CBCL, these women are also completing the Family Inventory of Life Events (FILE) and the Describing Your Neighborhood questionnaire. The child's medical chart will also be reviewed for relevant diagnoses and information.

Preliminary descriptive analyses of Phase One results suggest that our sample represents a higher risk group than those in the earlier studies by Friedrich et al. (i.e., higher percentages of single mothers and slightly younger, more racially diverse children from lower income families). However, the mean number of life events (stress), behavior problems, and sexualized behaviors in our sample are similar to those in normative samples. Caretakers reported 0 out of 52 cases of confirmed child sexual abuse and 2 out of 52 cases of suspected sexual abuse (3.8%) in our sample. Mean CBCL T-scores were in the average range with 6 out of 52 children (11.4%) obtaining moderately higher or higher scores. Mean CSBI scores appeared similar to those in original normative samples. Pearson product moment correlations reflected positive linear relationships between CSBI sexual behaviors and CBCL T-scores. Additional descriptive and inferential analyses, including ANCOVAs, are in progress to further clarify these and subsequent findings.

Future studies should include more cultural and developmental diversity, and should not exclude children with neurodevelopmental delays. In its preliminary phase, this study suggests that while such higher risk samples may be similar in composition to earlier clinical samples, the levels of behavior problems, including sexual behavior problems, may be more similar to those in earlier normative (nonsexually abused) samples. It may be useful to learn more about associations between children's medical, psychiatric, and developmental diagnoses and patterns of sexual behaviors in addition to exploring other potential covariates within groups of prepubertal children.

The Development of Social Interaction in Young Children with Autism in Head Start Using an Incidental Teaching Model

Jolene Ferro, Lise Fox

Presenters: Jolene Ferro, Lise Fox

Young children with autism exhibit substantial impairments in social interaction skills. Studies in which social interactions are taught are often directive (i.e., normally developing peers are taught to initiate social interactions with the children with autism). Incidental teaching methods are less directive and have been shown to be effective in teaching other skills. The purpose of this study was to assess the efficacy of using incidental teaching methods to increase the social play of young children with autism in Head Start classrooms.

One four-year-old male with autism and 19 other children enrolled in a full-day, full-year Head Start classroom participated. The target child functioned below his chronological age in communication, social, cognitive, motor, and self-care skills. The classroom teacher implemented the incidental teaching technique. She and the aide held CDA certificates but had no prior experience with children with severe disabilities. However, the staff received 10 hours of training about autism and specific training, including some coaching, about the child's skills.

Data included social level of play (six levels ranging from solitary to reciprocal play); social initiations and responses; the length of interaction; and interaction partner. Data were also collected to ensure correct implementation of the model and to assess the frequency with which the other children initiated social interactions with the target child.

Behavioral data were collected using a partial-interval recording system in which children were observed and data recorded every 10 seconds for 10 minutes. Interobserver reliability was calculated to be above 80%. An ABAB reversal design was used. After the first baseline, the teacher received a short period of coaching in the use of the incidental teaching technique. Baseline and intervention sessions were conducted during center-time activities in which children were free to choose to play in one of five different classroom areas.

During both baseline phases, the target child spent most of his time in parallel or onlooker play. Social play with peers ranged from 0-15% of intervals with a mean of 0. During coaching, social play increased somewhat to a mean of 13% of intervals. During intervention, social play with peers increased significantly to a mean of 75% with a range of 10-88% of intervals. Interactions also increased. Social play was the highest play level demonstrated.

Further implementation of this procedure with other children in community settings is necessary in order to evaluate it fully. However, these data indicate that this procedure can be successfully used to increase social play and social interactions for a child with autism. The procedure also appears to be feasible for child care workers to implement in community settings. The teacher was able to implement the procedure during regularly scheduled activities and with the typical staffing ratio of one teacher and one aide for 20 children. The teacher indicated that she found the intervention techniques very similar to her typical interactions with children during play activities. She did not feel they were difficult to implement or too burdensome.

Program Practices Affecting Family, Parent, and Child Functioning in Families of Children with Disabilities *Sharon Lesar*

Presenters: Julie Hall, Marian Phillips

The role of families in promoting the development and well-being of their children has become an increasing focus of attention as professionals try to cope with the problem of how to serve young children with disabilities. With the current move toward recognition of the importance of families, professionals are challenged with ways to become more family-centered and be responsive to families' diversity, strengths, and needs. The present study specifically examined 1) factors associated with parents' assessment of helping practices of early intervention program personnel; and 2) the extent to which child, parent, and family background characteristics, program characteristics, and helping practices influenced parental appraisal of personal control and self-efficacy over needed services, resources, and supports.

The sample included 69 parents (88% mothers) of children with disabilities or at-risk for poor developmental outcomes between the ages of birth to five who were in eight different types of early intervention and preschool programs in eastern Tennessee. The programs could be organized into subsets of two program types: service location (home based or center based) and service group (birth to three years old or three to six years old). Participants completed various measures of perceived control and helping behavior, including the Helping Practices Scale, the Personal Control Appraisal Scale, the Early Intervention Control Scale, and a background information sheet. Stepwise regression analyses by sets identified the relative contribution of parent characteristics (age and education), family characteristics (SES), child characteristics (child age and diagnosis), and program characteristics (program type and frequency of monthly contact with parent) to the prediction of sources of variations in helping practices, program control, and self-efficacy.

Findings ascertaining the sources of variation in helping practices indicated that parent and family characteristics showed no relationship to helping practices. Only child characteristics was a significant predictor of helping practices. Tests of the partial correlations found that child's age, but not child's disability, associated with differences in helpgiver practices. Correlations indicated that both home-based services and intervention services for birth to three children were positively correlated with helpgiver practices, suggesting that home-based services and programs that serve birth to three-year-old children tend to use more effective helping practices. Greater helpgiver contact (in hours) with families was correlated with more empowering helping practices.

Findings from the regression analyses investigating sources of variation in perceived control appraisals and self-efficacy indicated that frequency of monthly contact and helping practices accounted for a significant amount of variance. Correlations indicated a significant relationship between perceived control and program type. This bivariate relationship indicates that parents' sense of control is enhanced when families receive services primarily in the home or programs that serve only birth to three populations. The findings clearly point to the fact that unless programs employ helping practices that actively help families to understand the needs of their child, deploy competencies to meet those needs, and feel a sense of competency over the desired outcomes, the chances of making positive impacts upon families will be diminished considerably.

Parent/Professional Partnerships in Screening of Children with Suspected Disabilities

Judith S. Bloch, John S. Hicks, Janice L. Friedman

Presenters: Judith S. Bloch, John S. Hicks

With the passage of IDEA (Individuals with Disabilities Education Act, 1990) early intervention and preschool education for children with or at risk of disabilities have received increased national visibility. Parental involvement and services to the families of children are important components of these programs. Including parents in the screening and evaluation processes is an important way to promote collaboration with child care staff. A model for collaboration was developed at Variety Pre-Schooler's Workshop (VPSW), a center that provides an array of services for young children with and without disabilities and support services for their families. This paper focuses on one construct of VPSW's model: parental involvement in the screening of their young child with suspected disabilities using The Five P's Parent Data Questionnaire (PDQ).

Parental involvement in screening (and later in evaluation) provides an ideal time to initiate collaboration. The task structures the beginning phase of the work; provides parents with much-needed direction at a time of emotional turmoil; and helps counteract their feelings of impotence. Because parents are at first so concerned about their child's well being, and realize there are state requirements for data collection in order to determine eligibility for services, most respond favorably to requests for information. Simple instructions will help them prepare ratings on the PDQ of their own child's performance based on their observations at home and in the community. Participation in this screening process will increase parental understanding of their child's functioning and the way his/her profile compares to other children of the same age.

The process recognizes parental expertise in matters that pertain to their own child and demonstrates professional respect for that capability. In addition, it increases the accuracy of the entry-level clinical evaluations and the appropriateness of entry level objectives. At VPSW, parental involvement and collaboration continues (if and when the child enters the program) with periodic assessments and goal settings throughout the child's enrollment.

The Five P's PDQ is an abbreviated form of the more comprehensive, statistically reliable and valid Five P's Educational Assessment. This instrument is used to 1) screen and/or evaluate children two to five years old with suspected disabilities; 2) determine the need for further diagnostic assessment; 3) develop entry-level annual goals and short-term instructional objectives; 4) develop a multisource, multisite evaluation; and 5) set the stage for ongoing parental involvement in their child's education program.

Ongoing research at VPSW has demonstrated the value of collaboration and parental involvement in assessment. VPSW is planning to present the results of a two-year study on their Home/School Collaborative Model to New York State's Sharing Successful Programs in the near future. Both studies provide evidence that supports the positive effect of parental involvement and home/school collaboration on both the child and the family.

Families, Children, and Diabetes: A Cross-Cultural Consideration

Claire H. Kohrman, Emily Leish, Ann Garwick, Clara Wolman

Presenters: Claire Kohrman, Emily Leish

In collaborative research between the University of Chicago-La Rabida Research and Policy Center and the Center for Children with Chronic Illness and Disability at the University of Minnesota, we examined how culture influences families' understanding of health, illness, and disability. It was our goal to find patterns that would help the health care system work more effectively with children, parents, and families to improve outcomes for children with chronic illness. For this study we considered three ethno-cultural groups in the United States, as they are defined by race and ethnicity: European American, African American, and Latino American. The indicators of culture documented were attitudes, beliefs, rituals, roles, and patterns of behavior. In this particular segment of the larger three-year research projection, children with diverse chronic illnesses, we studied families of children with diabetes, ages 5 to 12. We interviewed 17 families in two geographic sites, Minneapolis-St. Paul and Chicago, as well as the physicians identified by the families as knowing the child best, to understand the ways in which family attitudes, beliefs, and interpretation are congruent with or divergent from those of the physician.

Analyzing the interviews with qualitative methodology, we found that important differences across families emerged. However, there were also repeated similarities. All families reported that diabetes profoundly affected the structure of daily life, and that they appreciated and needed more information and, sometimes, support. They especially mentioned the importance of schools, camps, and role models for their children. In addition to these similarities we found notable differences in the attitudes, beliefs, rituals, roles, and patterns of behaviors among the families. However, these differences did not necessarily correspond to ethnicity and race. They reflected, instead, many other elements that appeared cultural in that they organized the families' daily lives and self definition. For example, some families identified religion as the organizing principle in their family; others identified their focus as family itself and the relationships within it as the organizing theme. Yet other families described their daily lives as organized by the diabetes itself; they were drawn into a "culture of illness." Some referred especially to their socioeconomic status while others, especially those who did not speak English, emphasized their racial, ethnic, or national identity.

Thus, identities were not simply racial or ethnic but rather multifaceted, that is, "composite cultural identities." Our interviews with physicians showed that they believed that race and ethnicity played little role in the care of children with diabetes. Furthermore, they were only partially aware of the cultural patterns that could help in communication with families, particularly in developing ways to provide information as it is needed and can be effectively used by families. In sum, these interviews with families and physicians demonstrate that there are patterns in the culture of families that health care providers can be alert to and understand. This information can make important contributions to the successful adjustment of families and their children.

Factors Predicting Competence in Children with Chronic Illness and Disability: A Longitudinal Study

Nancy A. Carlson, Traci L. Colvin

Presenters: Nancy A. Carlson, Traci L. Colvin

Research conducted in the Chicago area with caregivers of a child with a chronic illness has revealed that some families believe they have too many obstacles and not enough resources to adequately provide for their child. Still others are either unaware of the availability of existing services or are unable to access these resources for various reasons. To this end, our researchers are conducting a longitudinal study of a small number of African-American biological families who initially enrolled a child aged 4-22 months with a chronic illness or disability, to gain an understanding of the experiences of these families and the impact of the child's illness on family functioning. This study is part of a larger, multifaceted longitudinal study, "Project Resilience," following 200 families over a four-year period, conducted by the University of Minnesota's Center for Children with Chronic Illness in collaboration with the University of Washington.

The purpose of this quantitative and qualitative study is to investigate family resiliency, or the psychosocial impact of caring for a child with a chronic illness or disability, regardless of the specific diagnosis. Some of the variables measured include personality characteristics, health status, social competence, stress, coping, social support, cognition, and family functioning. Additional items to be explored include how factors interact and change over time as the child matures, the condition fluctuates, the family changes, and/or the environmental context changes.

A total of 30 families (31 children) was initially recruited into the study for a series of two interviews. The children participating in the study have a wide range of disabilities; the majority of the children enrolled in the study presented conditions such as asthma, sickle cell anemia, and bronchopulmonary dysplasia (BPD). Results from the first interview reveal a high level of resiliency in the families enrolled in the study, with all of the families having some sort of support network to rely upon. Our data also tend to show that for our study population, a child's illness or disability does have a predictable effect on family life. Those families with more severely ill children reported centering the family's activities (whether intentionally or unintentionally) around the child's health and medical/social service appointments.

Preliminary examination using data from the families' second interview with researchers indicates that all of the families have experienced some kind of physical or emotional upheaval in the family since the first interview. A majority of the families had moved at least once and/or had experienced a trauma to the household (such as a fire or death in the extended family). A substantial minority (38%) of the children had developed (or were diagnosed with) additional medical problems since the first interview. These children presented conditions such as allergies, asthma, and nutritional deficiencies (which led to developmental growth concerns). While many of the children in our study were doing well, almost half (48%) of the children's original conditions had worsened since the first interview. Many had either been hospitalized or treated in the emergency room of the hospital on several occasions during the average eight-month span between the first and second interviews.

However, all of the families who completed the second interview did not report only negative or traumatic events in their lives. In fact, two caregivers reported that they had gotten married since the last interview, and another three caregivers reported additional members of the extended family had moved in to assist the parent(s), thus increasing their support network. Overall, our results tend to echo those found in the larger study conducted in Minnesota and Washington, which is that resiliency in families is strongly tied to their ability to cope. These families learn to work together and learn interdependence with others.

WYSIWYG—What You Screen is What You Glean: Developmental Screening is Prophecy Fulfilling *John H. Meier*

Presenter: John H. Meier

Screening policies and procedures are crucial to program definition and quality because they determine the reported incidence and prevalence of disabilities identified within a given target population and consequent distribution of children in classrooms. The type, severity, and percentage of various disabilities initially sought and ultimately enrolled in a Head Start program, for example, depend on the purpose, design, and contents of the screening instruments and procedures and the interpretation of their results regarding which children will be selected for further evaluation and probable certification as having one or more disabilities according to Head Start official diagnostic criteria.

This presentation addresses the elements of a comprehensive screening, assessment, and intervention system and demonstrates how differing geographic and host locations, diagnostic staff capabilities, program rationales, and corresponding practices lead to different emphases and findings. By means of a series of tabular and graphic data displays, it becomes clear that if a given program expects to find a high incidence of a particular disability, its screening instrument(s) and procedures, staff training, and other resources seek/screen and find/glean a preponderance of that disability to the relatively lesser numbers of other disabilities (10% quota usually serves as approximate maximum, too).

For example, the national Head Start composite Annual Disabilities Report indicates that 67% of the children with disabilities are classified with speech impairments and 11% with health impairments (N=69,267). By contrast, a Head Start program in a nearby clinically oriented setting (Sinclair, UCLA, 1993) indicates 18% speech impairments, 12% health impairments, and 55% combined emotional disturbance and learning disabilities (N=159). Our local Head Start program, serving more than 5,000 children throughout the geographically largest county in the contiguous U.S., identified 55% speech impairments, 36% health impairments (including ADHD and high asthma incidence), to name some primary categories (N=505, 1995-96).

Such significantly different findings raise several heuristic and practical questions regarding the choice of screening instruments and procedures used to identify representative populations of children with disabilities in Head Start and other public preschool programs. This in turn raises the underlying concern that each local unit selectively finds the disabilities with which it feels most comfortable and/or competent whereas other equally eligible special-needs children are being accidentally missed or intentionally excluded.

Additional policy issues arise regarding the advisability of nationally establishing detailed standards for screening instruments and procedures including such considerations as 1) minimal psychometric properties (predictive validity, test-retest reliability, specificity and sensitivity); 2) user-friendly characteristics (clarity of instructions, scoring, reporting, interpretation, and computerization); 3) appropriateness (subject-friendly, culture-fair, multiethnic, program-related); 4) research compatibility (using universal developmental domains for comparability and outcomes studies across programs); and 5) costs (for materials, administration time, and staff training).

If developmental screening is prophecy fulfilling, who are the prophets? Are all children with all disabilities equal in the eyes of the law (and its prophets) or are some more equal (prophetable/profitable) than others? Furthermore, are some purveyors of screening materials profiting by preying upon both unsophisticated users and erroneously identified (false positive) or overlooked (false negative) children with disabilities?

Children with Special Needs

Children in Early Intervention Programs: Special Health Care Needs and Desire for Child Day Care

Howard Taras, Shelia Broyles, Julia Martino

Presenter: Howard Taras

There is less child day care availability for children with "special needs" than for other children. The availability of child care for the subpopulation of children with special health care needs is unknown. The aims of this study were 1) to determine what proportion of developmentally delayed preschool-age children (0 to 5 years) also have special health care needs; 2) to determine the nature of these needs; and 3) to assess if health needs further obstruct child day care placement.

The population consisted of 678 children attending special programs for developmentally delayed preschoolers and infants (ages 0 to 5 years) enrolled in 31 San Diego schools. There were 260 children under age three, and 418 between ages three and five. Teachers were given English and Spanish questionnaires to send home with each child. Nonrespondents were reminded by the teacher at least once to respond. Of the 678 subjects, a total of 384 completed their questionnaires (response rate of 57%).

Of all respondents, 105 (27%) had a child with one or more medical needs. Recurrent seizures (12% of total), use of a gastric tube (5%), and severe asthma (4%) were the three single-most-common reasons for this categorization. Of the total population, 78 (20%) responded that his or her child had a limitation of movement and used a wheel chair, had an orthotic, a brace, or used a walker. Of the total population, 37% had either a medical or physical disability. Children with limitations of movement but without special equipment and children with visual or hearing disabilities were included in this figure.

Of the study's total population of parents (all of whose children were receiving special education services), 132 (34%) looked for and successfully found child care, 125 (35%) said that the lack of child care was keeping a family member from active employment, and 93 (24%) responded that they would not take child care if it were available. Parents with children having a special health care need were more likely to respond that their difficulty with finding child care was because providers were unwilling to care for their child's disability ($p < 0.0001$). Likelihood of successful enrollment in child care did not differ between those with and without special health needs. Of the 132 using child care, 7% used center-based care, 34% used family day care, 36% used a relative or friend's home, and 45% had a baby sitter at home.

Based on study results, the following recommendations are offered: 1) early intervention programs are excellent places to identify children with special health needs and educate parents about child day care; 2) desire for child day care services should be elicited by school and consideration should be made to make this issue part of an IFSP; and 3) as early intervention programs have a health infrastructure to care for special health needs and since parents perceive health needs as a barrier to child care availability, consideration should be given to piloting arrangements whereby early intervention programs contract out technical support to neighborhood child care settings so that they may take on children with special health needs.

The Impact of Inclusion on Preschoolers with Disabilities and Their Families

Yvonne Rafferty, Vincenza Piscitelli

Paper not available

The Individuals with Disabilities Education Act (IDEA) requires states to place preschoolers with disabilities in the least restrictive environment (LRE). An overview of research on the LRE, including parents' attitudes towards inclusion, parents' concerns about inclusion, and the impact of inclusion on preschoolers with and without disabilities are provided.

Effective Instruction: A Comparison of Mexican-American and Anglo Mothers with Their Preschool Children *Robert P. Moreno*

Presenter: Robert P. Moreno

In an attempt to explain the low performance of minority and low-SES children on school achievement and related measures, researchers have examined the early teaching interactions of mothers with their preschool-age children. Observed differences in the teaching strategies of minority groups, as compared to their more successful counterparts, led many researchers to conclude that minority and low-SES mothers did not provide their children with the necessary early teaching experiences to ensure later success in school. However, much of this early research has been criticized for equating "poor" instruction with the teaching styles of the ethnic/racial minorities and low socioeconomic groups while suggesting that effective instruction is characteristic of nonminority and middle-class groups. More recently, scholars have emphasized the importance of using culturally meaningful tasks and settings in assessing the teaching and learning of mothers and their children in different cultures. Unfortunately, these cross-cultural studies have not involved ethnic and racial minorities in the United States. This is of particular concern for Mexican Americans who, as one of the youngest and fastest growing segments of the population, possess one of the lowest school completion rates of any ethnic or racial group.

Building on previous research, this investigation examines the teaching behaviors of Mexican-American and Anglo mothers using tasks and procedures that may be more indicative of common "everyday" instruction. The study focuses on two basic questions: 1) what are the differences in the teaching behaviors of Mexican-American and Anglo mothers; and 2) how do these maternal teaching behaviors relate to their children's performance?

The sample consisted of 36 mother-child dyads, 17 Mexican-American and 19 Anglo-American. The children's mean ages were 53.4 months ($SD = 6.8$ months). Of the 36 children in the sample, 20 were male (10 Mexican-American, 10 Anglo) and 16 were female (7 Mexican-American, 9 Anglo). All mothers were English proficient, with English used predominantly in the household.

The findings suggest significant differences in the teaching behavior among the two groups, despite statistical controls for maternal education and household income. Anglo mothers were found to use more nonverbal teaching behaviors than their Mexican-American counterparts. The study also found that the two groups differ in the intercorrelations among the instructional behaviors. Finally, results of the study found the use of praise and directives (over more controlling teaching behaviors) to be positively associated with children's performance for Anglos. This is consistent with previous findings. However, this pattern is not found in the Mexican-American sample. Of all the instructional behaviors measured, only commands are associated (although negatively) with children's performance. This is true despite the Mexican-American children showing greater gains in task performance.

Collectively, the findings suggest that the instructional path that leads to children's task competence may take multiple forms. These differences may have important implications for later school success. If the academic success of ethnic and racial minority children can be hindered by the discontinuity between home and school, then these findings may allow early childhood educators to identify and utilize culturally consistent instructional practices with young Mexican-American children.

Early School Performance of Hmong Children in Comparative Context

Daniel P. Mueller, Edith M. Gozali-Lee, Carey Wexler Sherman

Presenters: Edith M. Gozali-Lee, Daniel P. Mueller

This study examines how Hmong refugee children are performing in American schools. The academic performance and classroom behavior of Hmong first and second graders are compared to those of their classmates from other ethnic backgrounds. This study is part of the ongoing evaluation of the St. Paul Head Start-Public School Transition Demonstration Project. Six inner-city elementary schools in the St. Paul School District are participating in the longitudinal study. The schools are divided into "Demonstration" and "Comparison" clusters. Cohort I entered kindergarten in the 1992-93 school year ($n = 248$ children) and Cohort II entered kindergarten in the 1993-94 school year ($n = 280$ children). All children are from low-income families; half attended Head Start. Nearly half of the children (46-47%) in each cohort are Hmong, 26% are Caucasian, 12-13% are African American, 14-16% are from other backgrounds (Latino, American Indian, and other Asians). Nine out of 10 Hmong children are receiving ESL services. Baseline assessments were conducted in the fall of the kindergarten year in each cohort, and subsequent assessments are conducted each spring.

Children's academic achievements in reading and mathematical concepts were measured by the Woodcock-Johnson Tests of Achievement. Teachers rated each child's social skills using the Social Skills Rating System. Information regarding school attendance was obtained from school records each year. Family background characteristics and parent involvement in the child's education were measured using an interview with a parent or a guardian of the child each spring. For Hmong families, all instruments included in the interview had been translated into the Hmong language and were administered by bilingual interviewers.

Reading achievement test results indicated that there were no differences in average scores between Hmong and other children. Hmong children and other children started at very similar baseline reading scores upon entering kindergarten. Hmong children also progressed at about the same pace as other children. On the mathematics achievement test results, Hmong children started kindergarten with significantly lower scores than other children. However, by the spring of the first grade they had "caught up" with their classmates. Teachers rated Hmong children favorably, particularly with regard to classroom behavior. Teachers rated first and second grade Hmong children as more cooperative, having more self-control, and showing fewer problem behaviors. In addition, our findings indicated that several factors may be related to better school achievement for Hmong children.

Being part of the Transition Project and Head Start was associated with higher reading achievement. Smaller family size and older parental age were also associated with higher reading achievement. Results in math achievement indicated that higher levels of parent volunteering in the schools and higher rates of school attendance were associated with higher mathematical skills. Early school performance results suggest that Hmong children are able to perform at similar levels as other low-income children in reading and mathematics. Head Start attendance and Transition Project participation may be partly responsible for their success.

ASHA's Building Bridges Multicultural Preschool Project: An Inservice Education Program

Dawn C. Ellis, April Massey, Tommie L. Robinson, Jr.

Presenters: Dawn C. Ellis, April Massey, Tommie L. Robinson, Jr.

Significant changes in who is served, how they are served, and where they are served are the earmarks of preschool service delivery in the 1990s. By the year 2000, one third of the projected U.S. population will consist of African Americans, American Indians, Asian Pacifics, Latinos, and other people of color. These trends forecast the need for personnel who are well prepared to work with culturally and linguistically diverse preschool children and their families, despite the fact that such preparation is rarely part of professional education for individuals in any discipline.

In 1993, the American Speech-Language-Hearing Association (ASHA) was awarded a four-year, U.S. Department of Education grant entitled, ASHA's Building Bridges: Multicultural Preschool Project. The project design includes three phases: 1) development of instructional materials; 2) demonstration of an inservice education program for preparing speech-language pathologists, audiologists, and preschool personnel to work more effectively with culturally and linguistically diverse preschool children with disabilities and their families; and 3) evaluation of project participants and instructional materials.

The project is conducted as a cooperative effort between ASHA and state speech-language-hearing associations. Each state is offered a one-day inservice education program in conjunction with the regularly scheduled state speech-language-hearing association meetings. Presenters are project faculty/module authors. Participants receive a module content manual. Participation in the one-day inservice is free for individuals registered for the state association meeting. The project was field tested in fall of 1994.

During the field-test period, data were collected relative to prior training in dealing with culturally diverse preschool populations. All participants were instructed to complete an evaluation form enclosed in their instructional materials. The forms were collected by an on-site coordinator and given to project staff. The evaluation information was entered into the data files using the R-Base database computer software package. ASCII data files were created in R-Base, then imported into SPSS Base for Windows. Descriptive analyses were computed as appropriate. Results indicated that of the total number of respondents ($n=1156$), 42.7% indicated that continuing education activities were the primary means for learning information germane to cultural and linguistic diversity. Thirty-six percent indicated that information was learned on the job, while 20% indicated no prior training at all. Only 21% of respondents showed evidence of receiving training during graduate coursework. However, it is interesting to note that these results were higher among those participants who were from more diverse states (e.g., California, Alaska, Washington, DC). Descriptive analysis further indicated that the majority of participants were more knowledgeable of cultural and linguistic diversity with the three to five age group than with birth through two.

These results show the lack of prior inservice/training among professionals serving diverse preschoolers and suggest the need for continued personnel training and the establishment of standards to meet the ever-growing diverse communities.

Parenting Styles of White, Latino, and African-American Families: A Study of Former Head Start Families

Tonja Rucker

Presenter: Tonja Rucker

Socialization refers to the process by which individuals acquire the knowledge, values, and behaviors that enable them to become competent members of society. During early childhood, this process of socialization is the primary responsibility of the family. A part of this socialization process is how parents parent their children. How parents interact with their children differs from family to family depending on a number of factors. This study investigated how ethnicity and gender of the children impacted the type of parenting style employed in the family.

The purpose of the study was to determine if there were differences in the ways parents of differing ethnic backgrounds report parenting their children, and if these differences were based on the gender of the child. The two questions that pertained to this study were: 1) are there differences among White, Latino, and African-American parents on the four dimensions of nurturance, responsiveness, nonrestrictiveness, and consistency; and 2) are there differences among White, Latino, and African-American parents on the dimensions of nurturance, responsiveness, nonrestrictiveness, and consistency based on the gender of the child?

The data for the present analysis came from a large number of parents of former Head Start children who were completing their first year in kindergarten. The sample of parents was drawn from eight public schools within a large suburban school system in the northeast. One hundred forty-eight parents responded to the family interview. Fifteen of the parents identified themselves as White, 54 as African American, and 79 as Latino. Seventy-one parents identified their child as male and 77 as female. Fifty-eight percent of the parents completed high school and more than half said they were currently employed. Slightly half of the parents said their monthly income was between \$800 and \$1,000 per month.

To assess parenting dimensions, an abbreviated form of the Parenting Dimension Inventory was administered by trained data collectors primarily within the schools. The measure assesses parental warmth, control, and structure. The first 26 items on this inventory assessed four dimensions of parenting: nurturance, responsiveness, nonrestrictiveness, and consistency.

Significant differences were found on three of the four parenting dimensions for ethnicity, but no significant differences were found based on the gender of the child. African-American parents reported more nurturance than Latino parents; White parents reported higher levels of nonrestrictiveness than African-American and Latino parents; and Latino parents reported more consistency than White parents.

Parents of different ethnic background reported differences in their parenting styles. Along with one's ethnicity comes beliefs and practices that influence the type of interactions that occur within the family. Parents' everyday experiences differ according to their ethnicity. The socialization practices that they employ are a function of their cultural beliefs and status or position in society. Researchers need to assess these everyday processes and identify what is valued as important to specific ethnic groups.

Cultural and Linguistic Diversity

Challenges and Approaches to Studying Latino Children and Their Families

Maria P. Fracasso

Presenter: Maria P. Fracasso

Perhaps as a result of challenges that confront researchers studying low-income immigrant groups, the social and emotional development of Latino children living in the inner city has remained virtually unexamined. Undoubtedly, concerns about collecting data in potentially dangerous environments, where many Latinos live, may contribute to the lack of empirical research efforts. Moreover, disparate language and appearance between many researchers and Latinos may make it difficult to recruit participants, enter their homes, establish a relationship, and maintain involvement. Finally, lack of familiarity with social science research may make participants uncomfortable and reluctant to participate in studies that require them to visit strange settings such as a university laboratory. Specifically, the purpose, as well as potential benefits, of the study is unclear. This paper addresses and describes issues typically encountered and unique approaches that were undertaken in several studies conducted to determine individual differences and normative development of infants born to recent immigrant Central American mothers.

Successful strategies employed in accessing and informing mothers about the specifics of the research included 1) developing lists of community agencies, clinics, churches, and centers to discuss details of the project; 2) advertising in the local Latino newspapers; and 3) broadcasting public-service announcements and discussing the details of the project on local Spanish radio stations. Thus, by soliciting help from the community, mothers were more amenable to participate since it was condoned socially by others whom they trust. In order to maintain, enhance, and ensure participation, strategies involved consistent and frequent communication with mothers by assigning only one bilingual female assistant, making periodic telephone calls, sending letters, visiting the neighborhood, and providing families with tangible incentives such as baby products, transportation, and financial compensation.

During design of these studies with Latinos, issues revolved around cultural appropriateness of questionnaires and procedures previously designed for non-Latinos. To limit linguistic differences, techniques included translating and back-translating interviews using bilinguals, reviewing questionnaires by monolinguals, and discussing final questions by both bilingual and monolingual Spanish speakers. The problem of ensuring accurate responding and interpreting the questions by mothers, as well as reporting the results, was eliminated by reading each question to all mothers. Also, to ascertain cultural appropriateness of a procedure designed for use by other ethnic groups, other similar mother-infant dyads pretested the paradigm. Finally, since home visits involved potential danger, physical safety was preserved by visiting homes in pairs, during daylight, dressing inconspicuously, and carrying only nonvaluable materials.

Despite cultural disparity, when equipped with effective research approaches to overcome potential barriers with sincere regard for the individuals they wish to study, even the most difficult circumstances in which research is conducted can be overcome.

A Model of the Relationships between Children's Cognitions, Interpersonal Negotiation Strategies, and Psychological Symptomatology: The Role of Family Ethnicity

Joshua L. Brown, Stephanie M. Jones, Faith Samples
Presenters: Joshua L. Brown, Stephanie M. Jones, Faith Samples, Nina Chaudry

There is widespread concern about the high levels of violence sweeping the country and about the adverse consequences on those exposed to it. Trends in juvenile violence indicate salient problems for African-American, Latino, and other minority youth who are frequently poor, residing in urban centers, and more likely to be victims of violent acts. The importance of examining the role of race and ethnicity becomes increasingly more important as the rates of violence among minority youth continue to rise.

Several studies indicate variability by race in the processes that lead to antisocial behavior, as well as in children's experiences with aggression. However, the possible direct or moderating effects of ethnicity have largely been ignored in programs designed to reduce or prevent the tide of violence facing many communities. To the extent that such programs fail to address the diversity of the populations they serve, it will be difficult to determine how children are differentially impacted by their exposure to preventive interventions aimed at reducing violence and violence-related behaviors.

The present study examines data drawn from an evaluation of a school-based violence prevention program, the Resolving Conflict Creatively Program (RCCP). More specifically, this study examines a model of the relationship between children's internal beliefs, fantasies, and attributions about aggressive and prosocial behavior; interpersonal negotiation strategies (INS); and psychological symptomatology. This will be done within the context of children's family ethnicity.

Results indicate that both ethnicity and gender are salient predictors of children's cognitions about aggression. More specifically, children who were non-White (African American rather than Latino) and female reported more aggressive fantasies and more hostile attributions and were less likely to have normative beliefs about aggression and prosocial fantasies. Regression analysis indicated that African-American children were significantly more likely ($p < .001$) than their Latino or White counterparts to report conduct problems.

Data also indicate that children who utilize an aggressive problem-solving strategy are significantly more likely to report conduct problems, over and above the effects of anxiety and depression. In addition, depression was found to be significantly related to conduct problems such that children with high levels of depression are likely to have more conduct problems. Differences across race/ethnicity suggest that these conditions were more likely to be true for African-American children than for their White or Latino peers.

Aggressive fantasies, hostile attributions, normative beliefs about aggression, and prosocial fantasies were all significant predictors of children's use of an aggressive interpersonal negotiation strategy among non-White children. Only hostile attributions and normative beliefs about aggression were predictive of the same strategy among White children. This may be explained by the fact that African-American and Latino children have realities that they are less than satisfied with, as compared with White children. That is, they may fantasize about being aggressive rather than risk doing so in communities where homicide rates are very high. Likewise, they may find it difficult to imagine helping someone if their own lives dictate that they first help themselves and their families.

Cultural and Linguistic Diversity

More specifically, the finding that African-American children are more likely to adopt an aggressive strategy when confronted with a problem-solving situation may be due to the perception and encouragement that youngsters receive from their communities. Oftentimes they are encouraged to fight back, and the message from the broader community may suggest that conflicts are resolved through violence. It may account for the need to use aggression in their interactions with others, as well as for the higher tendency toward depression and conduct disorder.

Maternal and Familial Factors That Promote Adaptive Motivational Behavior in a Racial and Cultural Context *Kari Keiser*

Paper not available

Willingness to seek challenges and persist in the face of difficulty are important adaptive motivational behaviors that promote academic and social success. Maternal and family functioning play a vital role in this acquisition. Exploratory research findings indicate interconnections between maternal and family functioning and children's motivational competence that are culturally and racially specific.

The Information Superhighway and Culturally Diverse Children *Ahmad Nuriddin*

Paper not available

Parental Stress and Support-Seeking in Mexican-American and Anglo-American Head Start Families

Margaret Garnett Sewell, Angela R. Taylor

Presenters: Margaret Garnett Sewell, Angela R. Taylor

The literature suggests two opposing hypotheses regarding parental stress and support-seeking in low-income Mexican-American immigrant populations. On one hand, because of the high value traditional Mexican culture places on family, Mexican-American parents (especially the immigrant generation) might be less likely than Anglo parents to seek parenting support from extrafamilial sources. Alternatively, because immigrant families are often cut off from traditional extended family or informal support networks, immigrants may exhibit more parenting stress than nonimmigrants, and seek more parenting support from extrafamilial sources, including Head Start.

The current study included 125 Anglo-American, U.S.-born Mexican-American, and immigrant Mexican-American mothers of preschool children attending traditional Head Start classrooms in a southwestern city. Subjects were participants in a larger longitudinal study, and were interviewed in English or Spanish regarding current (spring semester) levels of parenting stress, parental perceptions of current relationships with Head Start teachers and staff, parental expectations of emotional and practical parenting support from Head Start staff, and general preferences for sources of support on parenting issues (relatives, nonrelative peers and friends, or professional "experts"). Mothers also provided information on household composition, sociodemographic factors, nativity, years in U.S., ethnicity, and home language preferences.

The immigrant group did not differ significantly from the two U.S.-born groups in overall parenting stress levels. In nonsignificant trends, immigrant mothers reported somewhat less parenting stress than the U.S.-born groups, and Anglo-American mothers reported more parenting stress than the two Hispanic groups. Chi-square analyses indicated significant ethnic-group differences in preference for relatives as sources of parenting support ($p=.04$). The U.S.-born Mexican Americans were most likely to cite relatives as a preferred source of parenting support (83.7%), followed by the immigrants (72.7%) and the Anglo-Americans (50%). There were no significant differences in preference for teachers or friends as sources of support. However, the Anglos (100%) were significantly more likely to believe that Head Start staff should be able to provide such support, as compared to the immigrants (85.7%) and the U.S.-born Mexican Americans (69.8%); $p=.019$. Across groups, seeking support from relatives ($p=.02$) or friends ($p=.01$) was associated with lower parenting stress.

Neither of the initial alternative hypotheses appears to be conclusively supported. Consistent with the first hypothesis, both immigrant and nonimmigrant Latino mothers were more likely than Anglo mothers to go to relatives for parenting support, if available. However, contrary to that hypothesis, there were no significant ethnic or acculturation differences in willingness to use extrafamilial sources of support. With respect to the second hypothesis, immigrant mothers did not report higher levels of parenting stress than the more acculturated groups. However, as compared to the U.S.-born Latino mothers, the immigrant mothers were slightly more inclined to seek support from teachers and to view Head Start as an appropriate source of such support, perhaps due to less access to traditional support networks.

Head Start National Study: Bilingual and Multicultural Program Services

Katherine Hayes, Paul Longo, Luis Laosa

Presenters: Patricia A. Hamilton, Katherine Hayes

In the last three decades, the United States has undergone a dramatic shift in its sociodemographic composition that has important implications for America's educational policy. The United States is changing from a predominantly European White society to one that is increasingly racially and ethnically diverse. These changes indicate a need to re-examine the ways in which social and language interactions take place and to incorporate diversity into educational services.

This two-year study on Head Start bilingual and multicultural program services provides information on Head Start-eligible children and families from diverse backgrounds, and on the services available to them. Funded by the Administration on Children, Youth and Families (ACYF), and conducted by SocioTechnical Research Applications (STRA) and its subcontractor, Juarez & Associates (J&A), the study contains the following goals:

- 1) To characterize the bilingual and multicultural populations eligible for Head Start Services. Census data is accessed and analyzed by region, cohort, income, race, ethnicity, and language spoken in the home in order to provide a profile of currently eligible families and children, and to identify past and potential future trends;
- 2) To describe the number and distribution of children and families of bilingual and multicultural backgrounds currently being served by Head Start. Existing Head Start databases are analyzed and complemented by mail survey data;
- 3) To determine the characteristics of current efforts by Head Start grantees throughout the United States to assist families in bilingual and multicultural settings and to maximize the effectiveness of the Head Start experience through bicultural and multicultural service delivery. A national mail survey provides information on existing Head Start bilingual and multicultural services. The survey also develops the descriptive profiles of innovative programs;
- 4) To document common and unique features of current programs that are related to the development of social competencies of children in bilingual and multicultural environments. In-depth assessment of 20 innovative Head Start programs identifies successful or promising approaches to service delivery and their potential for adoption into other settings.

The study combines quantitative assessments of the eligible and served Head Start populations and qualitative analysis of the actual delivery of services to Head Start children from bilingual and multicultural environments. Information is provided through research that integrates existing Head Start and U.S. Census data with survey information collected from all grantees, and with qualitative in-depth research at 20 sample Head Start programs. The results describe the population eligible for Head Start services, the population being served by Head Start programs, and the nature and range of services being provided. Information gained from this study will be used by the ACYF to guide future policy and programmatic decisions and to improve the quality and effectiveness of Head Start programs to families in bilingual and multicultural settings. The final report is scheduled for release in October 1996.

Research Knowledge about Culturally Diverse Preschool Children with Disabilities: Access to Nine Disciplines *Gil Guerin, Ann Selmi*

Presenters: Gil Guerin, Ann Selmi

Trends toward the inclusion of children with disabilities in regular preschool programs and federal laws requiring that these children have access to the least restrictive environment have forced professionals who work with young children to become more knowledgeable about disabilities and to learn skills needed to assist these children. The new 1995 guidelines of the National Association for the Education of Young Children (NAEYC) reflect these changes and support the preparation of all early childhood personnel to work in settings that include children with disabilities.

However, even a cursory survey of available research on preschool children with disabilities reveals that knowledge in this field is spread across many disciplines. The challenge is having access to the most relevant information needed to answer questions and solve problems regardless of the professional source of knowledge. Specific databases, such as ERIC, Medline, or Psych Abstracts provide only limited ability to locate information that crosses professions.

To help overcome barriers to easy access to research information about preschool children with disabilities, a reference database has been created that includes a comprehensive survey of journal writings from nine related professions. The professions include audiology, nursing, nutrition, occupational therapy, physical therapy, psychology, social work, special education, and speech-language pathology. This database makes it possible to quickly identify relevant articles on any preschool topic related to disabilities. In particular, this study provides a description of the database and the results of a search for articles on ethnic, cultural, and linguistic diversity among preschoolers with disabilities.

A list of professional journals was obtained from computer compilations and by visual searches of library shelves of three large universities and one large medical center. The development of the database determined that there were 145 professional journals in the nine professions that contained articles from the years 1988 to 1995 that related to preschoolers with disabilities. The number of articles totaled 3,631, involving the full range of disabilities. The average number of articles that were added each year was approximately 400 and did not include the professions of child development or general education which were currently under development.

Results indicate that the percent of articles written about children with disabilities that included a diversity issue in the title is relatively small. It ranges from 0% in physical therapy journals to 7% in psychology journals. Additionally, data on cultural and linguistic diversity demonstrate that all professions, except for physical therapy, have produced literature on preschool children with disabilities, with special education producing the largest number of articles. Finally, findings indicate that speech-language pathology, nutrition, and psychology journals provide the most articles on ethnic issues, and nursing, audiology, and occupational therapy provide the least.

Findings from this survey demonstrate that the number of articles related to ethnic, cultural, or language diversity in these professional journals is very small when considering the amount of attention these subjects receive in the public forum. It would seem that if preschool service providers were to be responsive to the needs of the families they serve, their research and literature would need to reflect the emerging ethnic, cultural, and diversity issues of the families in this country.

Effective Practices in Serving Young Children: Ideal Environments for Learning Language

Robert E. Chubrich, Donald E. Mowrer

Presenters: Robert E. Chubrich, Donald E. Mowrer

Many children who are reared in an environment that lacks adequate stimulation are observed to display cognitive deficits by 18 months that may be irreversible. These children are ill-prepared for school learning experiences, and their growth toward becoming responsible adults is threatened. It is estimated that no more than 10% of parents adequately prepare their children during the first three years of life to become as well educated and socially developed as they can or should be. This presentation suggested practices that can enhance cognitive, language, and literacy development in young children.

Three types of parent-provided experiences have been identified that help children become competent. First, the child is provided with many small manipulable objects. Second, parents provide a great deal of what is called "teaching on the fly." Lastly, parents establish clear and consistent rules about what the child can and can not do.

Two factors are positively correlated with the rate of word acquisition in young children. Firstly, the child must make contact on a regular basis with a large number of adults other than family members. Secondly, trips taken outside the home each week help promote child language development. The amount of time spent watching television is negatively correlated with the rate of word acquisition.

Many commercially produced instructional materials are available that are designed to help professionals and parents provide good, growth-producing environments for young children. For example, The Purdue Home Stimulation Inventory is designed to evaluate the richness of a child's environment. It includes assessment indicators such as the number of times the child is taken out of the neighborhood each week and whether the home has a place where the child can be out of the range of noises or away from other people. The Home Observation for Measurement of the Environment, a diagnostic instrument that contains six subscale scores, also provides parents with useful information for assessing the quality of the home environment.

Several reading- and writing-like behaviors known as "emergent literacy" precede and lead to the development of conventional literacy. Literacy is embedded in the normal course of human activity rather than in a set of isolated skills. The young child who amuses herself by making marks on an envelope while waiting in line with her mother at the bank is engaging in emergent literacy. Another example of emergent literacy is when a young child scribbles on a piece of paper, tapes it on his bedroom door, and announces that the sign says it is his room and no one else can enter, or when a three year old helps her mother sort coupons into different stacks.

We, as professionals, have the knowledge and the responsibility to provide information that can help guide and support parents provide a home environment designed to foster the development of competent children who will benefit from and thrive in the school environment.

Effects of College Students' Child Development Knowledge and Their Selection of Discipline Approaches *Shi-Ruei S. Fang, Linda E. Derscheid*

Presenter: Shi-Ruei S. Fang

The amount of formal education obtained by a teacher is very important in preparing appropriate teacher behavior. Currently, Head Start and other early childhood programs need to meet only licensing requirements for hiring criteria for head teachers. State licensing requirements vary but are often minimal. In many states, Head Start and other early childhood head teachers only need six credit hours of college courses in child development in order to meet licensing requirements. The purpose of this present study was to investigate whether the number and type of child development courses would influence college students' responses to discipline situations. It is believed that discipline is one teaching area that needs appropriate teacher behavior or best practices.

Two hundred college students, mean age of 22.7 years, were recruited from six different college courses from the same department at a midwestern university. The Scale of Adult Responses to Children's Behavior (ARC-B) was administered. The students were asked to choose among three discipline approaches when viewing 15 slides depicting different child behavior problems. The three discipline approaches were 1) child oriented, the best practice, which involves the adult explaining to the child why the behavior was wrong and what behavior is correct; 2) task oriented, which involves the adult doing or completing the task for the child; and 3) adult oriented, which involves the adult either asserting his or her authority and demanding a change in behavior, or giving a reproach or punishment to the child. The college students were asked to record how many and which developmental courses they had taken.

Using the likelihood-ratio chi-square analysis, significant differences in responses were found for 6 of the 15 slides when comparing students having taken no, one, two, or more than two child development courses. Students taking fewer than three child development courses gave more task- or adult-oriented rather than child-oriented discipline responses on six slides.

Also, significant differences in responses were found for 6 of the 15 slides when comparing students currently taking no child development courses, human development courses, child discipline or practicum courses, or other advanced child development courses. Students taking either no child development or only a human development course gave more task- or adult-oriented rather than child-oriented discipline approach responses.

Five slides depicting different child behavior problems elicited significantly different responses in the students. Four of those five slides depicted child behavior problems involving infractions of an adult rule. The other slide depicted a potentially harmful situation involving pretend aggression: a pretend sword fight.

In conclusion, six credit hours in child development may not be enough for students to learn appropriate practices in discipline. Students taking advanced child development courses gave more child-oriented responses, especially to discipline situations that were oriented to adult convenience.

The results of this study support the notion that formal education and training is needed for early childhood teachers to improve their ability to interact effectively with children.

Curriculum and Classroom Practice

The Effects of the Reggio Emilia Approach on the Question-Asking Behavior of Head Start Teachers *Gail Brummit, Anne Rice*

Presenters: Marlynn Levin, E. Anne Rice, Patricia Weissman

Reggio Emilia is a city in northern Italy. Its municipal early childhood system has been recognized and acclaimed as one of the best systems in the world. For over 30 years the system has evolved a unique and innovative philosophical perspective, curriculum, and pedagogy. This system is built on the recognition that relationships or partnerships among parents, educators, and children are crucial. Classrooms are organized to support a highly collaborative, problem-solving approach to learning. Other important features are the use of small groups in project learning and the community-based management system of government.

The Merrill-Palmer Institute of Wayne State University, in collaboration with the City of Detroit, Human Resources Head Start Program, is engaged in a demonstration project providing technical assistance for the development of 10 Reggio-inspired Head Start classrooms. Training began in February 1995 and will continue through the 1996-97 program year.

The purpose of this study was to measure the use of divergent versus convergent questioning techniques in two groups of Head Start teachers: those who are receiving technical assistance in the Reggio Emilia approach and those who are using traditional early childhood education approaches (e.g., High Scope, Developmental). The results indicate that the teachers in the Reggio-inspired classrooms do not differ significantly from teachers in the traditional classrooms in the use of divergent question-asking techniques.

Zimmerman and Bergan reported that early childhood teachers who are trained in a process-oriented curriculum—one that attempts to teach varied intellectual operations rather than knowledge acquisition—alter their question-asking behaviors by using fewer cognition and memory questions and more perceptual questions than traditional preschool teachers. The results of this study do not support their findings. Measuring a discreet behavior, such as the frequency of types of questions asked by teachers, in a single observation may not adequately capture the quality of the interaction between teachers and children under varying classroom conditions.

Existing literature suggests that the implementation of a process-oriented curriculum may result in higher levels of teacher-student conversations. Therefore, it may be worthwhile to examine differences in teacher-child dialogues, particularly the responses to teachers' questions. A comparison of child-child interaction patterns (e.g., conversations, negotiation, and perspective-taking skills) between children in Reggio-inspired classrooms and those in traditional classrooms also warrants investigation. Finally, it may be useful to measure changes in the teachers' classroom practices over time as they become increasingly adept at integrating the Reggio Emilia approach into their classrooms.

Measuring Developmentally Appropriate Practices *Martha Abbott-Shim, John Neel*

Presenters: Martha Abbott-Shim and John Neel

The National Association for the Education of Young Children (NAEYC) introduced the concept of developmentally appropriate classroom practices in 1987 in their publication, *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8*. Operationalizing the meaning of developmentally appropriate practices through classroom observations has been addressed by numerous researchers. Bredekamp initially identified three factors in her assessment of early childhood classrooms: preschool curriculum, positive interactions among staff and children, and balanced schedule of activities. Harms, Rossbach, and Clifford found four factors: 1) active teaching; 2) provision for learning activities; 3) routine care; and 4) provision for motor development.

This research study used larger sample sizes for more appropriate analyses of the construct of developmentally appropriate practices using the Assessment Profile: Research Version. Initial analysis included 401 preschool classrooms from three different research studies: 121 classrooms in Georgia, Massachusetts, and Virginia; 122 classrooms in California; and 158 classrooms in San Francisco, Richmond, Newark, Miami, San Antonio, and Detroit. The auspices of the programs serving the three- and four-year-old children were diverse. They included center-based child care, Head Start half-day preschool, and school-sponsored preschool programs under both private and public auspices.

A factor analysis of the 75 items on the Assessment Profile: Research Version was run using tetrachoric interitem correlations with varimax rotation. Five factors accounted for 61% of the variance in the items.

The subsequent factor analysis includes 830 kindergarten and first-grade classrooms in Alabama, Arizona, Florida, Illinois, Indiana, Maryland, Minnesota, Nevada, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, and Virginia with the National Transition Evaluation Demonstration Project. These public school classrooms have children enrolled who previously attended Head Start.

A tetrachoric interitem correlation matrix was factor analyzed with a varimax rotation. Five factors accounted for 61% of the variance in the items. Given the different populations, it would be surprising if the factor analyses produced identical structures. Although the structures of the two factor analyses differ somewhat, we were pleased to see five factors accounting for 61% of the variance in both analyses. It should be noted that there were additional factors in each analysis, but these were factors with only one or two items loading per factor.

There are five common factor structures across preschool and kindergarten/first-grade settings. The order of factors differs; however, the same concepts are represented in the five factors. Three of the factors share multiple items in common across the settings. These factors are 1) accessibility of variety of learning materials; 2) intentional balance of activities; and 3) response to and encouragement of child's emergent learning and self-control. Two of the factors in each analysis represent the concepts of individualizing and inclusion, although only one item in each factor is shared.

Designing a Multicultural Competence Social Support Curriculum for Head Start Parent Advisors *S. Alease Ferguson, Elizabeth M. Tracy*

Presenters: S. Alease Ferguson, Elizabeth M. Tracy

In 1991, the National Head Start organization formulated a series of 10 Multicultural Diversity Principles for implementation nationwide. Local address of this mandate required 1) responding to a changing community demographic; 2) developing a relevant research-practice agenda; and 3) designing culturally appropriate staff, parent, and parent-child inservice workshops. The case of the Parent Network Project illustrates the value of a collaborative action-research strategy in the creation of processes and activities that "give back" by yielding tangible products that further organizational strides in rendering culturally appropriate services.

The Parent Network Project Manual's development was directly informed by the findings of a cross-sectional survey of 78 Head Start parents from three program sites; and a complimentary process of co-inquiry activities between the university research team, Head Start staff, and parents. Building a successful interorganizational collaborative meant establishing both relationships, services, and products consonant with the project's themes of equity and social support. Goal attainment meant engaging the participation and input of all levels of the Head Start system.

To support both the Head Start Staff Development and Parent Training needs, a curriculum and series of informational products were developed via co-inquiry to integrate the themes of social support and multicultural diversity competence. These products sought to 1) cultivate culturally sensitive attitudes and behaviors in the service delivery process with newly immigrant, culturally and linguistically diverse families; 2) increase the families' capacity to assess their social support networks and resource needs; and 3) increase overall group awareness and access to those informal and formal culturally specific resources within the local community.

The training sequence was comprised of four discrete but interconnected modules. Key content included Multicultural Diversity Preparedness; Social Support Network Interventions; Eliciting Positive Family Participation; and The Valuing Multicultural Diversity and Social Support Film Festival. A multicultural resource guide was also prepared to provide wider access to community educational, employment, arts, recreational, and social services programming. Also created were intercultural parent-child activities and the *Head Start Herald*, published in English, Spanish, Vietnamese, Arabic, and Russian. It featured information on Head Start, cultural diversity, literature, health immunization, household safety, and resource and support phone lines. A total of 120 families participated in the initial process.

Prevalence of Humor and Laughter in Head Start Classrooms *Donald E. Mowrer*

Presenter: Donald E. Mowrer

Research reports indicate that the teacher's use of humor in the classroom can be beneficial both to the teacher and to the students. When teachers use humor in their classrooms, it may aid in getting across their message, ease tension, diffuse hostility, evoke and maintain listener attention, and facilitate memorization of information. Humor may be used to facilitate the acquisition of a variety of cognitive and perceptual skills, including psycholinguistic and linguistic abilities, concept development, language development, and problem-solving techniques, as well as to improve children's social adaptive behavior.

The purpose of this study was to analyze the use of humor, wit, and laughter as exhibited by teachers and children during group discussion sessions in Head Start classrooms composed of children from lower socioeconomic levels.

Twelve 20-minute tape-recorded instructional sessions were collected from 12 classrooms randomly selected from a pool of 120 Head Start classrooms in North Florida. The 12 tape-recorded sessions were scripted and analyzed to identify occurrences of teacher and child initiated humorous events and laughter. Eleven of the classroom teachers were African-American females; one was a White female. The 200 children in the 12 classrooms were between the ages of four and five and attended school four days per week. A humorous remark or behavior was considered as any one or a combination of 10 categories of humor including exaggeration, incongruity, surprise, slapstick, absurd, human predicament, ridicule, defiance, violence, and verbal humor (word play, riddles, puns, jokes, wisecracks, epigrams, etc.). Instances of laughter from the teachers and/or the children were identified.

During the 228 minutes of observation time, 10 teacher-initiated and 6 child-initiated humorous events occurred in 7 of the 12 classrooms. Twelve instances of laughter occurred in the seven classrooms. No humorous events or instances of laughter were found in the other six classroom sessions. It was concluded that teachers appear to suppress the use of humor in their classrooms. Humor and laughter in the classroom seem to be but a few of the outward manifestations of the teachers' educational philosophy. This suppression of humor may result from a philosophy that views the school environment primarily as a work experience in which play activities that include humor and laughter are inappropriate. This philosophy is in direct conflict with the position taken by those educators who argue that the use of humor in the classroom can be very beneficial both to the teacher and to the students. The recommendation emerging from this study is to provide Head Start teachers with training concerning how to use humor effectively in the classroom setting. It is suggested that the occurrence of humor and laughter may serve as a reliable indicator of the Head Start teachers' educational philosophy.

Can Young Children Learn How to Learn? Evaluations of Bright Start: A Cognitive Curriculum

Penelope H. Brooks, H. Carl Haywood

Presenters: Penelope H. Brooks, H. Carl Haywood

One goal for every preschool curriculum is that it instill an ability to learn efficiently. In spite of the recognized importance of knowing how to learn, very few curricula evaluate this aspect of effectiveness. Since learning how to learn is such a critical part of school success, we have made it the focus of Bright Start (a cognitive curriculum for young children) and its subsequent evaluations.

Bright Start is a systematic, theory-based curriculum for use with children from three to six years of age who are at high risk of learning failure in the primary grades. It is both a cognitive and a metacognitive curriculum. Bright Start consists of four main components: an interactional teaching style that stimulates thinking; cognitive small-group units that focus on specific cognitive abilities; a cognitive-mediational behavior-management system; and a parent participation program.

Using the mediational teaching style developed by Reuven Feuerstein, teachers ask thought-provoking questions like "How did you know that was the right one" and "How else could you have solved that problem?" The advantage of this style is that trained teachers can adapt the level of individual interaction to the children's knowledge base, thus making integrated classrooms relatively easy. The interactions in the small group lessons provide the scaffolding for learning.

The seven units consisting of small group lessons are about cognitive abilities that apply to children's lives and are tools for thinking. Generalizations to everyday life are constantly encouraged and, indeed, are an integral part of the curriculum. Students are asked to "bridge" to their homelife and other aspects of their school life.

The curriculum has been used widely in the United States and abroad with children who have handicaps (mental retardation, learning disabilities, cerebral palsy, speech and/or language delays, emotional disturbance, deafness) or who are at high risk of learning failure. It has been translated into several other languages besides English, namely Hebrew, French, Dutch/Flemish, Spanish, and German.

Eight evaluations of the curriculum, varying widely in scope and quality, have been conducted in several countries. All report positive gains in many domains made by Bright Start children. Dependent measures (across evaluations) include abstract and representational thinking, McCarthy Scales of Children's Abilities, PPVT, Gardner Expressive Language Test, Peabody Developmental Motor Scales, assignment to Special Education classrooms, following instructions, comparing, reading, Raven's Colored Progressive Matrices, WISC-R, Mazes test of intrinsic motivation, self-regulation tasks, and dynamic measures of learning ability. These evaluations have shown that participation in Bright Start improves intelligence test scores, changes teachers' behavior by increasing process-oriented questions, and changes students' behavior by producing more enthusiasm for mental work, more process questions, more metacognitive answers, and better performance on many other cognitive and motor measures.

These findings confirm that learning-how-to-learn is extremely valuable when integrated with regular curricula. Bright Start is an effective vehicle for that instruction because it teaches children about their own thinking processes and their own behavior and how to think about everyday problems.

Kindergarten and First-Grade Teaching Practices Mediate Preschool Effects

Nikolaus Bezruczko, Marcia Kurland, Jeanne Borger, Karen Eckert

Presenters: Nikolaus Bezruczko, Marcia Kurland, Jeanne Borger, Karen Eckert

A topic not receiving adequate attention from contemporary social researchers is the influence of elementary school classrooms on the long-term benefits of early educational intervention. Consequently, the purpose of this research is to identify several specific elementary classroom conditions that sustain the immediate cognitive benefits of early educational intervention. Our research shows that kindergarten and first-grade classrooms that 1) actively engage children with school materials; 2) encourage the creative expression of children in their writing and talking; and 3) provide children an opportunity to work together on learning activities sustain the benefits of early intervention through elementary school significantly better than classrooms without these characteristics. Conversely, our research shows that classrooms emphasizing 1) dictatorial instructional approaches; 2) uniform learning with inflexible behavioral outcomes; and 3) teachers who subordinate the needs of children to the rules and structure of the educational system sustain early intervention benefits less well than classrooms and teachers not showing these characteristics. Additionally, elementary classroom experiences are cumulative, and, by chance, children end up following one of three distinct educational trajectories: 1) optimal classrooms sustaining early benefits the greatest; 2) a middle trajectory showing some fade-out of early intervention benefit; and 3) a third trajectory showing the greatest fade-out, representing classrooms with extremely poor classroom practices.

A startling outcome of this research is the mixed support it provides for "developmentally appropriate" practices. In separate studies using two kindergarten cohorts, we found kindergarten and first-grade classrooms with interest centers, literacy-rich environments, and children making choices showing significant statistical relationships with the richness of content in children's stories, their mastery of print, and their scores on first-grade standardized reading and math tests. In general, however, developmentally appropriate practices did not show significant relationships with both performance assessments and standardized measures of achievement. For example, the variables 1) children engaged with materials; 2) teacher is warm and caring; and 3) child-centered program only showed significant relationships with the content of stories and the mastery of print. However, these variables did not show significant relationships with standardized measures of reading and math achievement. Likewise, the variables 1) teacher working with children; and 2) hands-on activities also correlated significantly with writing composition, but not with standardized reading and math scores. An alarming result concerned children working together and oral language interaction. As expected, they correlated positively with the content of writing, but not with the acquisition of print. They showed an alarming negative correlation with both reading and math test scores.

These results are based on an ongoing longitudinal study of early childhood intervention for poor, African-American children in federally-funded Chicago Child-Parent Centers, Head Start, and State of Illinois funded preschools and kindergartens involving two cohorts of children. This study implements a methodology using multiple assessment sources, including both performance-based samples and norm-based standardized measures, as well as classroom observations. In future research, we will use these measures to establish long-term relationships between early and elementary school learning environments and adolescent literacy and competency.

Brighter Beginnings through Parents: Culturally Respectful Curriculum for Parents and Infants and Toddlers *Ruth J. Kahn, Carol M. Hosaka*

Presenters: Ruth J. Kahn, Carol M. Hosaka

Brighter Beginnings is a family-centered process-oriented curriculum based on sociocultural and constructivist theories of learning and development. There are seven training modules that are available: Reciprocal Consultation, Mediating Learning Strategies, Building Knowledge, Dynamic Assessment, Cognitive Actions, Supervision, and Parent Training.

Training procedures and instructional materials ensure that 1) interventions are respectful of the cultural values and individual needs and aspirations of each family; and 2) parent participation, as reciprocal consultants and transdisciplinary psychoeducational interventionists, is maximized. Interventionists and parents or other caregivers learn how to scaffold young children's learning experiences in order to enable the children to function in the zone of proximal development.

The primary goals of the program are to 1) facilitate and enhance the cognitive, language, and socioemotional development of infants and toddlers; 2) prepare young children for future schooling opportunities; 3) strengthen and enhance parent/infant attachment and interactions; 4) enable parents to become effective mediators of their young children's learning experiences; and 5) expand parents' abilities to problem-solve and advocate for their children in the future.

Parents are coached as they use the Affective, Cognitive, and Enabling Mediating Learning Strategies (ACE:MLS) materials. The materials are written on approximately a fourth-grade level so that parents with limited literacy can access them. As they use the implementation materials, parents learn how to effectively implement ACE:MLS to capitalize on naturally occurring educational opportunities. They also learn how to determine the best strategies to use in different contexts and to accomplish the goals they have set. Parents are encouraged to use ACE:MLS during the developmentally appropriate (Bredenkamp, 1987) and culturally sensitive activities that they generate for their children.

The original research and demonstration project involved African-American, Puerto Rican, and Caucasian families who had typically developing, at-risk, or disabled infants and toddlers. Economic resources ranged from those relying exclusively on government assistance to families with two professional salaries. The interactive instructional methods and procedures of Brighter Beginnings have been replicated with Native Hawaiian families with at-risk infants, and with families from the infant/toddler program at Lexington School for the Deaf in New York City.

Changes in parents' use of mediating strategies over time, the positive impacts of program participation on children's development, and changes in the children's use of mediating strategies have been documented and evaluated through analyses of videotaped mother/child and father/child play interactions when children were four months, one year, two years, and three years of age. Children's developmental changes were periodically assessed using a variety of standardized norm-referenced and criterion-referenced instruments. Parent satisfaction surveys and semistructured parent interviews also contributed data supporting the program's success. A program evaluation study is currently underway at the Lexington School.

The "Let's Think About It" Program for Parents of Preschool and Kindergarten Children

Carol S. Lidz, Lisa Chase Childers

Presenters: Carol S. Lidz, Lisa Chase Childers

The "Let's Think About It" program is a parent education program for parents of preschool and kindergarten-age children. The program encourages "mediational" interactions of parents to facilitate the development of a foundation for thinking and learning in young children. The program focuses on six core ideas. Research in child cognitive, metacognitive, and literacy development suggests that these six core ideas are important for effective thinking and problem solving. These core ideas are as follows:

- 1) **Noticing Our World:** This unit focuses on enhancing the child's perceptual experiences, as well as encouraging the child's ability to note distinctive features, detect patterns, compare, and categorize.
- 2) **What's The Big Idea?** This unit addresses issues of basic principles and rules and helps children to integrate information from multiple sources to develop a general thought or idea.
- 3) **That's Fantastic!** This unit encourages children to use their imagination and to go beyond their perceptual experiences into the world of fantasy. This includes the ability to make unusual and unique combinations and to develop "what if..." thinking as a basis for scientific thought.
- 4) **Let's Make a Plan:** This unit helps children anticipate the future and connect the present with the future. Helping children to make a plan introduces the ideas of sequencing and strategizing. This offers an opportunity to consider means-end thinking, also involved in science and logic.
- 5) **Looking Backward:** Just as planning looks to the future, this unit helps children to make connections between the present and the past. This is an opportunity to focus on cultural transmission, to nurture cultural/historical roots, and to develop cause-and-effect thinking.
- 6) **The Nimble Symbol:** This unit directly focuses on laying a foundation for literacy and numeracy. Children become sensitized to the symbols in their environment and learn to make, use, and appreciate these symbols.

Each unit offers a minimum of six activities for each objective from which parents select. Each unit is also accompanied by a vocabulary list to encourage development of verbal tools for the basic concepts of the unit.

The "Let's Think About It" program spans eight weeks and combines weekly discussions with home-based activities. Each session presents a new unit and reviews experiences with the activities from the previous unit. The activities require few if any special materials and most often capitalize on naturally occurring events within the family. Parents are encouraged to view the activities as examples that express the objectives of the unit, and to develop their own ideas. The focus is on embedding learning in a fun-based interaction.

Embedded within the program is encouragement of adult-child interactions guided by the concepts of Mediated Learning Experience (MLE), as developed by Feuerstein and his col-

Curriculum and Classroom Practice

leagues. MLE outlines and summarizes specific components of adult-child interactions that facilitate optimal cognitive development in children. Related to the work of Vygotsky and adapted and expanded by Lidz, MLE includes components such as: intent (regulation of attention and involvement of the child); meaning (attributions of value, highlighting the distinctive features); and transcendence (connecting present with future, past, and hypothetical thinking). There are a total of 12 components that provide guidance to parents and are embedded in the introductory discussions for each unit.

The design of the program represents a collaboration between a college research psychologist, a preschool classroom teacher, and a committee of volunteer parents. The program was piloted with a group of well-educated parents in the fall of 1995, with positive results as measured by their ratings of satisfaction with the program and self-ratings of their interactions with their children. The program will be used with a group of New York City Head Start parents in the fall of 1996. An abbreviated Spanish version of the program is in process with parents of preschool children in Puerto Rico.

Public Preschool Teachers' Views on the Meaning of Risk Status and the Relationship between Risk Status and Children's Readiness for Kindergarten

Kimberly G. Browning

Paper not available

Teachers' Reading Style and Head Start Children's Engagement in Shared Reading

Deanne A. Crone

Paper not available

Learning to Pay Attention: A Collaborative Home-School Program to Develop Attention Management in Children Enrolled in Head Start

Ann Turrell, Lucia French, Omeri Nwachi, Lorraine Gianvecchio, Susan Chuang

Presenters: Ann Turrell, Lucia French, Omeri Nwachi, Lorraine Gianvecchio, Susan Chuang

Attention is considered to be the foundation of most cognitive and neuropsychological functions. Attention problems, including attention-deficit/hyperactivity disorder (ADHD), are among the most common disorders based in childhood. The goals of this study were to 1) achieve a better understanding of what attention is and how it develops in young children; 2) provide analysis of the pedagogical practices that influence attending behavior in early childhood education classrooms; and 3) establish a parent-teacher-researcher collaboration to design and implement a program fostering the development of attention.

This study attempts to build on a multidimensional view of attention as a construction. A model of Constructed Attention is proposed that views attention as a process embedded in the developing knowledge base of the child and the context within which attending occurs. The influence of the knowledge base is suggested to increase as attending moves from focus to sustaining levels. The Constructed Attention Model would construe ADHD as a problem learning, multi-etiological in nature. Emphasis is placed on identifying educational strategies to support attention rather than diagnosis of disability.

A two-year multilevel research model using both qualitative and quantitative methodology formed the basis of this study. During the initial year, teacher- and parent-definitional frameworks for attention were obtained using survey and focus-group interviews; an ethnographic study of 10 classrooms examined interactional patterns and classroom practices as they impact attention; and interval-time samples of 132 children's attention investigated relationship to gender, program, teacher, instructional activity, and peer attending. The second year, collaborative case studies were completed for six children in two classrooms identified by staff as High, Medium, and Low regarding attention. Parents and teachers agreed to collaborate with the researchers in providing assessments of attention and creating individual plans for development of attention.

Key results suggest that attention was not identified as a primary goal for early childhood education, but problems in attention were common concerns for both parents and teachers. Parents defined attention associated with compliance and more passive focus while teachers described a more active, engaged process. Contingency Table Analyses suggested that neither gender nor income was significantly related to attention. The nature of the classroom program and specific teacher did influence mean attending scores, as did the nature of the instructional activity. The use of attention management resulted in significantly high mean attending scores while behavior management for inappropriate behavior produced lower mean attending scores. Case studies illustrated the importance of context in attending and demonstrated the utility of assessment of attention in developing and implementing strategies to support attention at home and school. Results at each level supported the view of attention as multidimensional and contextually dependent.

The integration of qualitative and quantitative approaches provided a meaningful basis for understanding the contextual basis of attention. Contextual influences can be assessed and child behavior can be interpreted in response to the interactional and instructional experience. Future study will advance both theory and practice when we are able to move beyond preoccupation with disability. The challenge is to obtain greater clarity in identification and analysis of the multiple influences embedded within the context of home, school, and culture that contribute to the construction and development of attention.

The Family in the Community

Overcoming Barriers to Continuous Comprehensive Services for Children and Families in Urban and Rural Communities

Laurelee Ahlman, Elaine Raspel-Borth, Carola Pfortner

Presenters: Laurelee Ahlman, Elaine Raspel-Borth, Carola Pfortner

The provision of health, education, and social services for children is undergoing a radical change. Restructuring and reform efforts in these areas integrate comprehensive services for children that include their families. Partnerships are forming among agencies having children in common as they increase collaborative efforts in providing services for both children and families. As part of a National Head Start Public School Research Demonstration Project, three school districts, six Head Start agencies, and social service agencies representing urban and rural communities have formed local collaborations to conduct research and develop services for kindergarten through third-grade children and their families. The three collaboration projects hold a shared vision of an integrated system of services. Although specific strategies for fulfilling that vision vary by site according to different economic and cultural community dynamics, a common thread exists in the types of strategies that work and the types that must be redesigned. Cultures and ethnic groups in these sites represent great diversity: African American, Alaskan Native Indian and Eskimo, Hmong, Samoan, Japanese, Korean, et. al. Families from more than 100 different ethnic groups participate in the three projects. In this approach, the needs of children and families are met through proactive, comprehensive services resulting from systemic change, rather than reactive services in a one-shot crisis mode. Sites believe that a continuum of services in addition to informal staff networking ensures smooth interprogram transitions, as well as sustained benefits for children and families.

Traditionally, health care, social, and educational services for children and families are predicated on the basis of crisis intervention. These three research and development sites face this every day as they struggle to become proactive, with services designed through family self-assessment in an effort to stave off crises before they occur. Crises include job loss, fire/eviction/no living space, death/divorce/other separation, medical emergencies, loss of transportation, abuse, and behavioral/mental health issues.

The three site-based projects encounter barriers to services for families in their communities, including nonexistent services, existing services limited by capacity, interagency conflict, client-agency conflict, lack of transportation, and bureaucratic delay. The formative findings from the sites appear to indicate that amelioration of these barriers, along with an increasingly proactive approach to meeting the needs of families, may significantly impact the abilities of families to increase the safe and thriving aspects of their lives.

All organizations and agencies who provide these services are responsible for responding appropriately to the needs of children and families, actively engaging the home, early childhood, and elementary school settings, and the community in working together to provide barrier-free supportive services for children and families in their individual family development. A continuum of services keeps the focus on the child and the family, instead of fragmenting services, thereby creating barriers by compartmentalizing the needs of the child and the family. The challenge will be to continue to provide a stable base for children and families while proactively connecting them to identified services.

Evaluation of Services Integrated through Partnerships: A Case Study

Jayanthi Mistry, Sheli Wortis, Lynne Hall and Elaine Schaeffer

Presenters: Jayanthi Mistry, Sheli Wortis, Lynne Hall and Elaine Schaeffer

This poster describes a three-stage evaluation of the Cambridge Partnership for Children, a city-wide collaborative program serving families and preschool children from diverse backgrounds. The Cambridge Community Partnership for Children, funded by the Massachusetts Department of Education, aims to create an integrated model of support services for urban child care centers and public kindergartens. The Partnership Program was created through the integration of services of several component programs: Early Childhood Connections, including Literacy Curriculum Connections and other support services to early childhood staff and families, and accreditation support services.

Partnership services were planned based on the assumption that a developmental continuum of services would most effectively impact quality of care. Ideally, accreditation support was to be initiated first to assist centers to achieve center benchmarks, before staff development programs such as Literacy Curriculum Connections were instituted. Since most participating centers experienced instability from year to year, a longitudinal comparative case study was designed to enable us to track changing center benchmarks and use of services from year to year and assess outcomes. Three sites representing different points on the developmental continuum of services were selected for a comparative longitudinal case study.

Stage 1. Evaluation of Accreditation Support: The first stage of the evaluation (1993-94) examined the relationships between center characteristics (e.g., staff turnover, population demographics) and the implementation of Partnership services. Stability of center administration and commitment of director to accreditation were the most salient center characteristics that were related to implementation of Partnership services. At the end of the 1993-94 year, each center was at different levels of readiness for NAEYC accreditation.

Stage 2. Evaluation of Staff Development Services: In 1994-95 the evaluation objective was to examine the relationship between staff development services provided by the Partnership Consortium and the quality of classroom teaching at the same three sites. Data collection, which took place at the beginning and end of the year, consisted of observations of teachers conducting shared reading sessions and follow-up activities, self-ratings by teachers, and interviews with project coordinators. All three centers made improvements in teaching practice, with the most gains made in the center that received the greatest amount of Partnership services.

Stage 3. Evaluation of Developmental Outcomes for Children: In 1995-96 the evaluation objective was to examine whether developmental outcomes for children were related to a center's status on the developmental continuum of services. Samples of children ($n=10$) from each of the three sites were followed over the 1995-96 year. In addition, data were also collected on a small sample of children ($n=7$) from a control site that served a similar population of children (many receiving tuition subsidies) but never received Partnership services. Children's literacy skills showed improvements over the year at the two centers that experienced relative stability in center administration or staff development services. However, at the center which experienced significant instability in terms of center administration and staff turnover, assessments of children's literacy skills showed no improvements over the year.

The Family in the Community

Community Collaboration in Action: The Development of a Family Resource Center

Karen Solomon, Karen Taylor, Lura G. Lohr

Presenters: Karen Solomon, Karen Taylor, Lura G. Lohr

Presented here is a case study of the development of a Family Resource Center in the Pine Knolls community in Chapel Hill, NC. The neighborhood, once a middle-class African-American community where home ownership was the norm, had become an area known for its poverty, drugs, and high crime rate. Social workers from the Transition Project (a federally funded Head Start Program composed of a social worker and educational coordinator) at the local elementary school became more aware of the increasing feelings of helplessness and fear among the families and children from the neighborhood whom they assisted. Working with several families individually could not bring an end to the isolation and anxiety that area residents felt, so the Transition Project team began to conceive a community solution that evolved into the development of the Pine Knolls Family Resource Center.

In 1993, the Transition Project began to facilitate meetings to initiate community changes. A coalition composed of residents, representatives from the Police Department, a local housing rehab program, the Housing Authority, community leaders, the YMCA, and the Town of Chapel Hill developed strategies to improve the quality of life for residents of Pine Knolls. The first changes included increased police surveillance of the neighborhood, revised reporting procedures of suspected criminal activities to guard against retaliation, improved physical condition of the dwellings and streets, no-cost quality afterschool care in the neighborhood, and increased training programs on parenting and employment.

These changes led to greater hope and participation by area families. In August of 1994, 22 residents of the Pine Knolls community met to prioritize the services and programs they felt their community needed. Building on momentum of the residents' commitment, the Transition Project staff sought financial resources for the establishment of a family resource center. In October of 1994, the Pine Knolls Center was awarded a grant through the North Carolina Governor's office Crime Prevention Bill. Matching funds were obtained from the Orange County Partnership for Young Children. At the same time, a community-oriented policing program was being established at the Community Center.

Community agencies have collaborated to provide resources for the physical facility as well as programmatic resources. The Family Resource Center is located in a house provided rent free by the local Community Association. Labor for renovations was donated by the Town; a security system was donated and installed by a private business, and renovation/reconstruction of a playground was funded through a variety of funds associated with the Orange County Partnership for Young Children. A lending library has been bolstered by private gifts and resources from area churches and citizens. A large array of programs and services are provided through community collaboration and cooperation. The YMCA operates an after-school program, with financial assistance from the Town and County. Volunteers from UNC (several academic disciplines, groups, and organizations) provide tutoring and other services to the community. The Chapel Hill-Carrboro School system provides computer and math skills building at the Resource Center.

A hallmark of the center is the very active, involved Governing Board, which is composed of 60% area residents and 40% community representatives. The hands-on composition of the Board allows the Center to develop services and implement programs that are responsive to changing community needs and flexible in delivery. It does take a village to raise a child!

BEST COPY AVAILABLE

Evaluation of a Collaborative Model of Prevention Interventions in Head Start Programs

Catherine Ayoub, Pamela Miller, Pamela Raya, Kathryn Geismar

Presenters: Catherine Ayoub, Pamela Miller

The development, maintenance, and evaluation of a collaborative model of preventive intervention services for young at-risk children in Early Start, Head Start, and Jump Start Programs and the training network for professionals was examined. The Harvard University Graduate School of Education (HUGSE), through its Risk and Prevention Program, has entered into partnerships with early childhood programs in order to meet two primary goals. The first goal is to provide a network of prevention services to young at-risk children and their families within the educational settings in which children routinely receive services. Such a partnership between community early childhood programs and institutions of higher learning can offer children and their families more comprehensive and holistic service delivery systems while simultaneously developing cost-effective and interactive networks among service providers and educational institutions. The second goal is to enhance the learning of both practitioners and graduate interns in the development, implementation, and evaluation of comprehensive systems of intervention for young at-risk children. Both practitioners and students serve as mentors for each other. Through this interaction, the relationship between career development and practice is enhanced.

In 1991, the HUGSE Risk and Prevention Program began its alliance with community-based Early Childhood centers. Services provided by graduate students and faculty consultants include in-classroom modeling, one-to-one in-classroom counseling and support, curriculum development, consultation around strategies for management of at-risk children in the classroom and the community, Pair Play Therapy, parent liaison work (workshops and one-to-one consultation), and ongoing community systems networking. Support and intervention as it relates to diversity and cultural differences is a central theme of the collaboration.

From the outset, the collaboration has been conducted at inner-city day care centers serving multirisk, multiethnic populations of toddlers and preschoolers. The children typically come from homes where caregivers have to cope with extensive economic hardship and limited social support. While the families we serve tend to be isolated, the communities where they reside are sometimes rich in human service networks. And yet, children at the centers have often been repeatedly exposed to illegal drug use, interpersonal and community violence, poor nutrition, and, in many cases, abuse and neglect or inadequate/inconsistent supervision.

These children are at high risk of developing inappropriate and ineffectual peer interactions, which are evident shortly after the child becomes representational and begins to model behaviors and interactions in the classroom. Within the collaboration, one intervention, Pair Play Therapy, has been cited by the Head Start Centers as the most important and innovative for at-risk children receiving services within the partnership. Pair Play Therapy (PPT) is a developmental intervention designed to help at-risk toddlers and preschoolers develop and sustain friendships with age mates.

We systematically examined the collaborative model by summarizing qualitative and quantitative evaluation material collected over the last three years from teachers, graduate students, parents, and administrators. We highlighted our use of pair play to support children who have interactional difficulties within the classroom and demonstrated how working with children in pairs has facilitated their development of friendships in the classroom through a series of video examples. Family involvement was illustrated through the presentation of a curriculum for parents on conflict resolution.

The Family in the Community

Early Intervention Referral Issues Surrounding Family and Staff Identification of Need for Services *Sandra Lee Owen, Richard Lambert*

Presenters: Sandra Lee Owen, Richard Lambert

The Early Intervention System (EIS) project of Dekalb County Head Start targeted a predominantly African-American population residing within the metropolitan area of Atlanta, Georgia. Specifically, EIS sought to better understand the special needs of grandparents serving as surrogate parents of Head Start children whose natural parent was drug impaired and deferred the care of the child to the grandparent. EIS responsiveness to these special needs through referral was influenced by teachers' fears of labeling the child and grandparents' adaptive behavior of isolation, autonomy, and fused family structure to keep out stress. Grandparents tended to isolate from the mainstream (traditional community services) and identify exclusively with an ethnic subculture (noninstitutionalized church) represented by the Atlanta Religious Mobilization Against Crime (ARMAC) program serving neighborhoods within the EIS catchment area. ARMAC counselors proved to be the missing link in meeting special family needs.

Data sources included teacher (N=22) responses to a 20-item survey; individual interviews of grandparents (N=25) and teachers (N=22); and contact logs completed by ARMAC counselors (N=6). Frequencies described quantitative data, while the constant comparative technique and substantive coding were used to analyze and classify responses into categories. The two evaluators used memos, field notes, and discussions between them to develop ideas and build inferences from the responses.

Taking the role of "gatekeepers," teachers influenced the EIS project's responsiveness to the special needs of families. Eighty-six percent of the teachers made no referrals to family service workers, EIS personnel, mental health, or ARMAC interns during the three-year project. Seventy-three percent of the teachers stated that the EIS staff education program did not increase their interest in making referrals. The EIS project director explained that the majority of teachers, teacher assistants, and paraprofessionals resisted reporting observations and making referrals because they didn't want to label the child. Once the child and its family are labelled as poor, Black, and troubled, subsequent community interventions are based on a deficit status. An ARMAC counselor stated, "Stresses in our culture right now produce real tension within families...drugs, unemployment, high mobility are all hurting families. The whole dependency/support structure has changed. There is a sense of real loneliness."

Grandparents adapted to this unresponsiveness by isolating and adopting a sense of autonomy based upon a feeling that they had been abandoned and could not expect help from anyone. Grandparents demonstrated their sense of powerlessness by creating overly tight boundaries insulating the family against additional stresses.

Realizing the potential of linking ARMAC with these grandparents, the EIS project entered into a partnership with ARMAC counselors. During the first year of this partnership, ARMAC counselors contacted grandparents by phone, respecting family privacy and developing trust. Home visits were made on the request of the grandparent. Ninety-five percent of the 947 contacts made by the counselors included specific help and follow-up contacts. During the second year, grandparents voluntarily participated in luncheon meetings with other grandparents to share experiences and resources. Those who participated described an increased sense of self-efficacy.

By linking grandparents with ARMAC counselors, the EIS project 1) respected the need of teachers to focus on the child's potential; and 2) promoted grandparents' ability to identify and utilize services relieving their stress and promoting their sense of self-efficacy.

An Ongoing, Multifaceted Researcher/Practitioner Partnership: Examples of Collaborative Projects

Jane A. Goldman, Jean E. Bell, Stephen A. Anderson, and Beena Achhpal
Presenters: Jane A. Goldman, Jean E. Bell, Stephen A. Anderson, and Beena Achhpal

In this paper we describe the collaborative relationship that has been established between faculty members in the School of Family Studies at the University of Connecticut and the staff of the ACCESS Head Start/PCC program in northeast Connecticut. Our purpose is to encourage both researchers and practitioners to consider a variety of ways, in addition to research, in which they might develop mutually supportive, collaborative partnerships. We believe that such partnerships provide a strong, mutually beneficial infrastructure for both research and program development. In the paper eight topics are discussed.

- 1) Program Administration: University faculty and students serve on the ACCESS policy council and committees. The ACCESS Head Start/PCC director served on the community advisory committee to the School, and on the search committee for a dean for the School.
- 2) University Teaching: ACCESS staff meet regularly with U-Conn classes.
- 3) Student Practicums: Head Start/PCC sites provide "real world" practicum experiences for university students interested in child development, early childhood education, family relations, social services, marriage and family therapy, and public policy. A graduate intern in marriage and family therapy just completed a supervised practicum providing in-home mental health services to families in the home-based program.
- 4) Staff Training: A U-Conn faculty member developed and conducted a series of monthly inservice seminars on mental health issues for home visitors and social service staff.
- 5) Program Development: Working together we developed plans for expansion of the mental health component of the ACCESS home-based program to incorporate graduate interns in marriage and family therapy. These students would conduct home visits in order to provide family support, parenting education, therapeutic intervention, child assessments, and observations of parent-child interactions.
- 6) Advocacy and Public Policy: In order to increase awareness of the unmet needs of children and families in northeast Connecticut, and to encourage advocacy for children and families, ACCESS Head Start/PCC and the School of Family Studies co-sponsored a legislative breakfast for state policymakers, including state legislators, town selectmen, and representatives of government agencies.
- 7) Grant applications: The ongoing cooperation between ACCESS and U-Conn has provided a strong infrastructure for collaboration on grant proposals. Proposals have focused on training marriage and family therapists in partnership with Head Start programs, staff training in family systems, and providing home-based mental health services.
- 8) Research: A Ph.D. student in the School of Family Studies, who also is on the Head Start/PCC Policy Council, is conducting research identifying similarities and differences in the beliefs and expectations of parents from Puerto Rican and Anglo-European backgrounds regarding Head Start programs.

In summary, as both researchers and practitioners, we have benefitted in many ways from our ongoing, multifaceted partnership. This collaborative relationship also provides a solid infrastructure for applying to future RFPs for program development, expansion of services, and staff training and development, as well as research.

The Family in the Community

Getting a Head Start in Collaborative Partnerships *Norman A. Peart, Donna M. Bryant*

Presenter: Norman A. Peart

The purpose of this study was to identify the benefits and concerns of community organizations about their work with Head Start programs in collaborative partnerships. The study examined the collaborative role of Head Start within one of the most innovative child care and early education initiatives of this decade, North Carolina's Smart Start Initiative. Smart Start is comprised of two interactive components: state government, which provides funding and overall direction, and local Smart Start partnerships, which coordinate agencies and services within their local counties. Currently, 31 of the state's 100 counties receive funding (\$60 million, to date) based on numbers of children under 6 in poverty. The goal of Smart Start is to improve early childhood and family services to enable children to enter school healthy and prepared to succeed. Smart Start has fostered partnerships within and between the public and private sectors to provide more and higher quality health, early childhood, and family services, particularly to low-income families. Because of its tradition in working with these families, the Smart Start legislation mandated that local efforts include Head Start.

The Smart Start-Head Start collaboration was examined in four counties. Data for the study were collected over a two-year period in order to accurately analyze the natural evolutionary adjustments that arise over time in the collaborative process. The result is, therefore, a dynamic, rather than a static, representation of the collaborative process. Individuals interviewed included Head Start parents and directors and Smart Start leaders, planners, and executive directors. Qualitative methods were used to comprehensively examine collaborative relationships. The collaborative partners noted various strengths of Head Start that included Head Start's parent involvement expertise and their 30 years of experience working with young children and parents. Some of the weaknesses these partners highlighted included Head Start's regulations hindering the degree to which their programs can fully collaborate and Head Start's failure to educate their community about available Head Start services.

Based on the themes that emerged and the information obtained from the personal interviews, the following four suggestions are made to maximize Head Start's collaborative partnership opportunities. First, provide a Head Start orientation to collaborative partners, and review the financial and operational policies, as well as the programs offered by Head Start. Second, advocate that Head Start parents are well represented on the collaborative board to allow them to play an active role in the collaboration. Third, offer Head Start's community service record and parent involvement assistance to the partnership. Linkages should improve service quality and may also lead to funding opportunities. Fourth, continue to reach out to a comprehensive array of services in the community, drawing those players together. These interactions should foster collaborative partnership opportunities.

Developing an Evaluation of Training Program for United Way-Supported Agencies

Robert E. Brown, Hiram E. Fitzgerald, Annette Abrams

Paper not available

Supporting Parents in a Dialogue of Understanding: Video Demonstration of a Family Support Curriculum Component *Joan Moir*

Presenter: Joan Moir

Opportunities for families to explore issues in child rearing prior to and during the parenting experience through video and videotaped playback (VTRP) experiences promote a strengthening in parents' perceptions in their roles as partner nurturers in child rearing responsibilities.

The utilization of photography as a vehicle for increasing parents' understanding of themselves in relationship to their child was documented in a study of 58 mothers with infants ranging from 7-14 months of age. The sample was divided into three groups: 1) playgroup and photography (E2); 2) playgroup (E1); and 3) control (C). The treatment subjects (E1 and E2; N=38) received 20 weekly, two-hour playgroup sessions using a developmental interactive approach. Nineteen of these subjects (E2) also received a photography curriculum, which included the study of mothers' roles, mother with her child, and mothers' playgroup observations. A quantitative-qualitative methodology was selected to investigate the photography curriculum's impact on new mothers' awareness in three domains of parenting: 1) child as a person; 2) parent-child relationship; and 3) parental role. Quantitative measures included the Parental Awareness Interview (PAI).

ANOVAs applied to the PAI showed significance by the E2 group on domains 1 and 3. Results also showed that the E2 group yielded higher mean scores on domain 2. The Mother's Program Experience Questionnaire (MPEQ) of photo album material indicates differences in playgroup value of experience between the E1 and E2 groups, with photography group (E2) demonstrating more interactional interest.

Reviews of family subject and event photography selections in photo albums suggest a negative relationship between picture-taking and stressful times. Emphasis in family albums is on physical and cognitive changes in developmental, social, academic, and religious events. Albums affirm victories, ownership, and happiness and selectively avoid pain, failure, and loss. They create an intergenerational legacy of "world view and ideology" from tacit photography selections. The use of video for expressive and reflective studies may serve to override some of the self-selection distortion that occurs in photo histories. Documentation of "sequential tracking" of the character and quality of relationships for the purposes of understanding the interactive dynamic between family members is more successful in video records.

Video recordings of discussion sessions between family members and the facilitator provide a vehicle for parents to share histories, feelings, and ideas related to their goals for themselves and their child. Within the context of a developmental interactive analysis of video and photo album recordings, parents are supported in building values, goals, and options in parenting. The value of creating time for reflecting on parenting role(s) and its relationship to parents' own experiences being parented and parenting provides opportunities for understanding, growth, and change. VTRP provides historical reference points for future comparative analysis. A follow-up study will determine if the VTRP experience would yield significance in the PAI mean scores on domain 2.

Family Support and Self-Sufficiency

Differences in Quality of Care by Adolescent Mothers

Debra Shelapinsky, Joan Vondra, Cynthia P. Liefeld, Richard Solomon

Presenter: Debra Shelapinsky

This study tested the power of a variety of indicators of the social and psychological context of adolescent motherhood for predicting differences in quality of care. Sixty-one urban, low-income teen mothers were observed with their first-born toddlers in the lab when their children were 18 months old and in their own homes six months later. Approximately half of the mothers had been enrolled in a comprehensive parenting support program shortly after the children were born. Self-report data on maternal age, race, residence (alone, with own parent, etc.), depressive symptomatology (via the Beck Depression Inventory), and parenting attitudes (via the Adult-Adolescent Parenting Inventory) were collected. Quality of maternal care was evaluated through observation and interview, with maternal sensitivity and responsiveness (appropriate, insufficient, or intrusive) assessed at the 18-month visit, and the developmental supportiveness of the home environment assessed at 24 months.

Hierarchical regression analyses tested the relationships among social and psychological risk factors, formal parenting support, and quality of caregiving. Regression analyses revealed that 1) maternal age, race, and depressive symptomatology were significant predictors of the developmental supportiveness of the home environment at 24 months, with younger, non-White, and depressed mothers providing a less supportive environment; 2) maternal race was a significant predictor of intrusive maternal responding at 18 months, with White mothers being most intrusive. No differences were found in quality of caregiving between mothers enrolled in the parenting support program and mothers in the control group, given the contributions of the other predictor variables. Similarly, maternal residence and parenting attitudes did not significantly contribute to prediction of caregiving quality when considered in combination with the other predictor variables. None of the predictor variables contributed significantly to maternal sensitivity or to either appropriate or insufficient maternal responding. Limitations of the study and implications of study results for further research, intervention services for adolescent mothers, and policy development were explored.

Changing Lives: New Hope for Low-Income Mothers

Fern Marx, Sharon Lynn Kagan, Muriel Hamilton-Lee

Paper not available

Qualitative and quantitative findings are presented on the three-year implementation of the Family Education and Training Program (FET). FET was designed to investigate the impact of a comprehensive child care training program on the employability of low-income women who are parents, and to assess the impact of such training on their job readiness, their skills in parenting their own children, and their children's cognitive and social competence.

Calling All Men: The Impact of Male Intervention

Mary Ann Adams, P. Ainsworth, L. LeFlore, T. Webb, P. McCullum, J. Adcock

Presenters: Mary Ann Adams, P. Ainsworth, L. LeFlore, T. Webb, P. McCullum, J. Adcock

The need for a better understanding of how to strengthen the family as the primary nurturer of its children is an issue that must include an examination of how to better involve fathers as a necessary component in their children's everyday life. Parent education and parent involvement models taught in the past have not included curricula that addresses the needs of fathers in a manner that would enable them to succeed in the multiproblem challenges faced in parenting their children. Male involvement is neither simplistic nor linear. Many facets of intervention must be considered.

The current study was the beginning of an attempt to understand the stress that fathers have concerning their involvement with their children. It also assessed the differences in stress that fathers have as opposed to mothers so that appropriate father education and father-involvement models can be developed.

The current study utilized the Parenting Stress Index by Richard R. Abidin to assess stress. This instrument assesses stress in the child in the following areas: 1) Distractibility—the parent views the child as hyperactive; 2) Adaptability—the parent views the child as unable to adjust to changes in his/her environment; 3) Reinforces Parent—the parent does not view his/her child as a positive reinforcement; 4) Demandingness—the parent sees the child as placing too many demands on him/her; 5) Mood—the parent sees their child as unhappy or depressed; and 6) Acceptability—the parent sees the child as not being what he/she had hoped for in a child. The instrument assesses stress in the parent in the areas of 1) Competence—high scores in this area are indicative of the parent not feeling competent in parenting skills; 2) Isolation—these parents feel socially isolated from their support systems and are under considerable stress (high scores on this scale show a need to establish an intervention program as soon as possible); 3) Role Restriction—these parents feel the role of parent is restricting their freedom and keeping them from having their own identity; 4) Depression—high scores reveal significant depression in the parent; 5) Attachment—the parent does not feel an emotional bonding with his/her child; 6) Health—high scores reflect a deterioration in the parents' health; and 7) Spouse—high scores reveal a parent who is lacking the active and emotional support of the other parent.

The results of our study revealed that Head Start parents scored high and in the critical range in each child area with the exception of Distractibility and on each parent area with the exception of Health and Role Restriction. This reveals that the stress level these families are experiencing is excessive.

If you compare the scores on the test for fathers and mothers, Head Start fathers reported significantly more stress than mothers in the child areas of Adaptability and Mood. In the parent areas, fathers reported significantly more stress than mothers in the areas of Isolation, Role Restriction, and Spouse. This is the beginning step in understanding the parenting needs that fathers have as opposed to mothers and in assisting us in developing more usable intervention and educational programs that target fathers.

Family Support and Self-Sufficiency

Family Self-Sufficiency: Descriptive Findings from a National Survey of Head Start Programs

James P. DeSantis, Jeffrey A. McLellan

Presenters: James P. DeSantis, Jeffrey A. McLellan

Data collected during 1994 through the National Survey of Head Start Family Self-Sufficiency Initiatives were used to describe Head Start programs' efforts in the areas of literacy, employability, and substance abuse. This survey was mailed to approximately 2,006 grantees and delegate agencies. The final response rate after seven months of data collection was 69% ($n=1,381$). Data were analyzed to describe 1) how programs identify families' needs for services; 2) services provided directly by Head Start programs or through collaboration with other community agencies; 3) barriers to helping families; 4) commitment of resources; 5) factors affecting Head Start collaboration with other agencies; and 6) programs' awareness of community services and their availability.

Analyses revealed four common types of assessment strategies used by Head Start programs to identify families' needs. These included the use of needs assessment forms and items on applications, referrals from other agencies, staff observations, and client requests for services. By far, the most common method of needs assessment was the use of forms for this purpose. However, staff observations played a significant role in identifying needs in the area of substance abuse services.

Most collaboration with other agencies was found to be based on informal agreements. This was true for collaborations in the areas of literacy, employability, and substance abuse. The propensity to collaborate did not appear to be influenced by the perceived level of need for services among families. The one exception was in the area of substance abuse, where a significant association existed between a Head Start program's perception of the level of need among families and the program's tendency to collaborate for the provision of ATOD assessments.

Lack of child care and transportation were consistently identified by program directors as serious barriers to helping families. Family denial of a problem was the most serious barrier identified in assisting families in the area of substance abuse. Further, Head Start programs serving proportionately more families with needs in each of the areas of literacy, employability, and substance abuse consistently identified more barriers to serving those families.

The majority of Head Start programs considered the following factors to help facilitate interagency collaboration: 1) community commitment; 2) availability of staff to engage in interagency networking; and 3) having informal contacts or associations. The most frequently cited factor in impeding Head Start programs' interagency collaboration was the level of funding or in-kind services.

Results also show that the vast majority of program directors were aware of literacy, employability, and substance abuse programs in their communities, with over 90% mentioning at least one program under each type of service.

Preliminary Results from the Evaluation of the Wisconsin Parental and Family Responsibility (PFR) Demonstration Program

Phillip A. Richardson

Paper not available

Use of the Family Assessment Tool (FAT) in the Nebraska Head Start/Public Schools Transition Demonstration Project

Beatty Brasch, Linda Hellerich-Tuttle, Helen Raikes

Presenters: Beatty Brasch, Linda Hellerich-Tuttle, Helen Raikes

The program for which data were presented is a Head Start/Public Schools Transition Demonstration Project. The Nebraska site is 1 of 31 participating in the federal project designed to provide Head Start-like services to children from five demonstration schools from kindergarten through third grade between 1992-93 and 1996-97. The project is a partnership of Lincoln Action Program (grantee), Lincoln Public Schools, and SRI Institute (a division of The Gallup Organization).

The FAT is an assessment tool used by case managers as they work with client families to help them achieve self-sufficiency and healthy family functioning. The tool's three primary uses are 1) planning (for the family and the worker); 2) research (documenting trends in family progress); and 3) program evaluation (formative for program development and summative for program effectiveness).

Based on family interview responses, the Family Outreach Worker assesses 21 family functioning dimensions to create a profile of strengths and needs. It also identifies areas exhibiting barriers to self-sufficiency and healthy functioning. A "barrier" is defined as the point at which circumstances change from being a positive to a negative influence on healthy functioning and self-sufficiency. From the profile, the worker and the family jointly develop a family goal plan that reflects the family's desire to address some or all areas considered barriers.

Future work with the family revolves around agreed-upon goals and the actual tasks involved in accomplishing change. Much time is spent on reinforcing family strengths and monitoring progress toward goal achievement. Re-assessment occurs every nine months. A total of 225 Transition Project families have currently been assessed with between 9 and 36 months of case management services. Major dimensions showing continuous positive change during that time include wages, income, and increased hours in the work force and increased wages with a reduction in use of AFDC and food stamps. Dimensions that showed little change from baseline to the 9- and 18-month assessments were substance abuse and mental health; however, these dimensions began to show positive change after 27 and 36 months of case management.

The Detroit-Skillman Parenting Program: Organizational Complexity

Kari Schlachtenhaufen, Barbara Wash, Elizabeth Burki, Charlene Firestone

Paper not available

A foundation, a health department, and two universities are involved in the Detroit-Skillman Parenting Program. The organizational complexity of this project is addressed. Actors bring to the collaboration their own organizational cultures and linkages.

Family Support and Self-Sufficiency

The Impact of a Comprehensive Early Intervention Program on Social Support among African-American and White Adolescent Mothers *Faith Samples*

Presenter: Faith Samples

With the United States leading virtually every industrialized nation in adolescent fertility, there is a need to provide families with the support necessary to ensure the healthy growth and development of our nation's children. Adolescent pregnancy and out-of-wedlock births are among the social and economic conditions that have made it increasingly difficult for families to sustain themselves now more than at any other time in the past. Both have been found to contribute dramatically to the stress that many families face, with overwhelming evidence for the adverse short- and long-term socioeconomic consequences. The primary concern is whether teenage mothers can effectively meet the needs of their infants when they themselves are grappling with developmental issues inherent in adolescence.

The present study is a secondary analysis of data drawn from the Prenatal/Early Infancy Project (PEIP), which was conducted in a rural upstate New York community in the late 1970s and early 1980s. This study examined the impact of the PEIP on the social support networks of poor, unmarried, African-American and White adolescent mothers. Simple descriptive statistic and multiple regression were employed for analyses of these data. Analyses tested the direct effects of race and of the PEIP on outcome variables (i.e., social support) and examined the moderating effect of race on the relationship between the nurse home-visiting program and adolescents' social support networks.

Results indicate that poor, unmarried adolescents differed significantly as a function of treatment-group status and race. Adolescents assigned nurse visits were significantly more likely than adolescents in the control group to anticipate child care and chore support at intake. Moreover, nurse-visited adolescents were found to receive more support during labor than control group mothers and to report higher rates of husband/boyfriend interest in their children at 6, 10, and 22 months.

Contrary to the study's hypothesis, control-group adolescents reported levels of chore and child care support significantly greater than those of mothers in the nurse-visited group at the eighth month of pregnancy and at the 6- and 22-month assessment periods. The treatment x race interaction term proved to be a significant predictor of expected support during pregnancy for control-group mothers. More specifically, African-American adolescents assigned to the control group were much more likely than their nurse-visited counterparts to expect high levels of chore support.

Implications of this work suggest the need for more support interventions that involve communities in their development and implementation so as to better address the needs of residents. Programs that are tailored to benefit the specific population being served, rather those assumed to have universal applicability, are much more likely to succeed in culturally and ethnically diverse populations. The extent that PEIP was able to enhance the level of male partner interest in their children suggest that it has important implications for Head Start programs that not only involve mothers but that increasingly focus on male partners as primary sources of support for young children.

Welfare-to-Work: Effects on Parenting and Family Functioning *Ariel Kalil*

Presenter: Ariel Kalil

Recently, policy analysts and developmental psychologists have called for research to investigate the effects of family supports included in the provisions of the Family Support Act in order to identify program supports that have a "two-generational" effect (i.e., those that are related to improvements for mothers as well as children). The educational accomplishments and brightening of future prospects for mothers who have participated in an education and training program might improve their self-esteem, motivation, and sense of personal control. Such improvements in mothers' mental health could lead to more effective parenting and concomitant improvements in children's academic, social, or behavioral adjustment.

This paper examines the effectiveness of a county-level welfare-to-work program on earnings and employment increases, educational advances, and welfare reduction. It also identifies "two-generational" program effects. Data were collected via a telephone survey of 41 mothers who had completed participation in a county-level Family Self-Sufficiency program. In addition to job training and tuition grants and scholarships, participants in the program received assistance with housing, child care, and transportation. They also participated in self-esteem support groups, parenting workshops, and education or career counseling. Mothers answered 15 questions concerning the degree of improvement they felt they had made in terms of their mental health, problem-solving skills, and relationships with their children. These items were submitted to factor analysis and were used to create four subscales: problem-solving ($\alpha .81$); personal happiness ($\alpha .72$); efficacy ($\alpha .79$); and confidence in the future ($\alpha .79$).

Analyses examined reductions in welfare receipt, increases in earnings and employment, and correlations among program participation, family functioning, parenting, and parental well-being. Results indicate that program participants enjoyed substantial monthly earnings gains, exhibited a significant decline in receipt of AFDC benefits, and reported improvements in their problem-solving abilities, personal happiness, mental health, and self-esteem as a result of having participated in the program. Associations among utilization of program services and educational advancement, earnings gains, and psychological well-being were also examined.

Participants in Project Self-Sufficiency enjoyed substantial gains in monthly earnings. All former participants reported that their psychological well-being was improved to at least a moderate degree. These outcomes are valuable not only for the well-being of the mothers, but also because improved psychological well-being is associated with more effective parenting skills and improvements in children's adjustment. Improvements in psychological well-being were also associated with educational advancement. This result suggests that psychological and social support may be an important component in the success of welfare-to-work programs.

Future work could improve on the present study by 1) examining change over time in psychological well-being and family functioning with data collected at two points in time; and 2) including a control group of participants in welfare-to-work programs who did not receive psychological and social support.

Family Support and Self-Sufficiency

Social Support and Low-Income Parents: Findings from a Head Start Parent Network Project

Elizabeth M. Tracy, S. Aleese Ferguson

Presenters: Elizabeth M. Tracy, S. Aleese Ferguson

This presentation furthers the understanding of social support and parenting by reporting social support data and findings from a cross sectional survey of 78 Head Start parents. Parents in three sites volunteered for the study. The aim was to better prepare Head Start parent advisors to strengthen the social support networks of Head Start families. The research sought to identify the social support strengths and needs of families for future staff training and family development programming. The researchers were particularly interested in gathering information from parents who were recent immigrants to the United States, since the Head Start sites involved in the project were struggling to meet the needs of a culturally and linguistically diverse population.

Three standardized questionnaires were administered by Head Start parent advisors. The Family Resource Scale assessed whether or not the family had adequate resources in such areas as time, money, and services. The Family Support Scale assessed how helpful social network members are to the family. The Support Functions Scale assessed the extent to which the parent felt a need for various types of assistance, such as someone to talk with or care for the child. A questionnaire gathering basic demographic information was also provided.

No significant differences were revealed between the immigrant and nonimmigrant group of parent respondents. Analyses of individual items for each of the scales provided useful information for staff training and family programming. For example, the type of help reported as being most needed by all parents was emotional support (e.g., someone to talk to for needed advice). The lack of money was cited as a need and a source of stress. Personal associations in their social networks were rated low in terms of the amount and quality of support provided, thus indicating that some social network relationships induce stress. Surprisingly, the social contacts from the program itself were rated nearly as helpful as the support received from spouse/partner. These results underscore the importance of promoting positive working relationships between staff and parents.

The findings held direct implications for the Parent Network Project, which developed a social support and multicultural training module for parents and staff. Each site received the Parent Advisor Training manual. Content included multicultural diversity, social network mapping, intervention skills, and fostering involvement of immigrant and nonimmigrant parents and a multicultural community resource guide. Parent multicultural support newsletters were prepared in five languages, and a series of parent and child social enrichment activities were held. The Parent Social Support Training Module included information on assessing support and increasing support. Activities reached 120 families across the three program sites.

This research activity grew as a successful interorganizational collaboration between a university and a Head Start Program. A discussion of directions for further research on social support and parenting and the lessons learned regarding implementation of research projects from both the agency and researcher perspective were provided. Key were well defined objectives and the importance of process and flexibility in roles.

Prisoners of Abuse: Implications of the Relationship between Domestic Violence and Welfare Receipt *Jody Raphael*

Presenter: Joan Meier

New research linking long-term welfare receipt and domestic violence has important implications for both welfare reform policy and service delivery strategies for low-income women and their children.

Taylor Institute's surveys of participants in grassroots welfare-to-work programs throughout the country have uncovered data demonstrating that large numbers of women already on welfare are enmeshed in violent and controlling relationships. Due to low grant levels, welfare participants cannot live on welfare alone. Accordingly, high school dropouts who become teen parents often become embroiled in relationships with males who promise to support them. In return, say program workers, these males want complete dependency. Threatened by educational and self-help programs, these men frequently resort to violence and emotional coercion to prevent their partners from gaining education and employment.

Data from almost 20 programs reveal a high incidence of past domestic violence, usually in the range of 50-60%. These data are troubling because of what we know about the effects of post-traumatic stress disorder and the need for a therapeutic recovery process for the women and children involved. Programs report a range of 22-80% of participants who are current domestic violence victims.

Anecdotal evidence suggests that many men, threatened by their partners' education and training, will continue to try to prevent them from involvement in literacy, job training, or employment. Therefore, without thoughtful assessment of domestic violence in welfare department offices, referral to therapeutic and support services and time for activities like safety planning, relocation to a safer community, and recovery from the effects of past domestic violence, state welfare reform efforts employing "fast track" job search and placement activities will result in violence and death for many low-income women and children.

Research documenting the link between welfare receipt and domestic violence mandates new methods of service delivery. Literacy, GED, job training and job placement programs serving low-income women must incorporate support and therapeutic services for domestic violence, and should also be alert to making certain that assessment of the children's needs occurs as well.

Head Start programs and others primarily attending to the needs and development of children must be more greatly attuned to the issue of domestic violence in the home and be prepared to provide intervention and support services to assist the mother in eliminating the violence. Experts believe that children exposed to domestic violence suffer the same harm and display the same symptoms as children who are actually abused, including the symptoms of post-traumatic stress disorder. If the trauma continues or is untreated, it impairs their ability to manage tension, frustration, and transition, and adversely impacts their school work and social relationships. Thus, domestic violence serves as a barrier to the mother's ability to raise her family out of poverty, while at the same time it seriously affects her children's ability to function and succeed.

Family Support and Self-Sufficiency

The Effect of a Comprehensive Child Development Head Start Program on Children and Parents of Low-Income Families

Todd Braeger, Sebastian Striefel, Michaelle Ann Robinson, Pat Truhn

Presenter: Todd Braeger

The Community-Family Partnership (CFP) program is one of the original Comprehensive Child Development Programs funded in 1989 by the Administration on Children, Youth and Families. In September 1995, the CFP ended its phase as a national service demonstration program and began funding within Head Start. The CFP maximizes the potential of economically disadvantaged families and children by providing comprehensive, ongoing, intensive, individualized services.

This descriptive study included 151 ethnically diverse families enrolled in the CFP. Families resided in two rural counties of northern Utah, had a pregnant woman or an infant less than one year of age, and an income at or below the Federal Poverty Guideline (FPG) upon enrollment. At any one time, 60 families are enrolled in the program. The CFP prepares children for success utilizing individualized child development plans and the provision of intensive early childhood services including 1) home-based early childhood education (age 0-3 yrs) and parent-education; 2) preschool services (age three to kindergarten); 3) early intervention for children identified as developmentally at risk; 4) day care; 5) nutrition and health care services; and 6) ongoing developmental screening and assessment. Sixty-two percent of the children assessed on the Battelle Developmental Inventory always scored within the normal range. Fifty-five percent of children scoring in the at-risk range scored 'normal' by their last assessment. These children were enrolled on average 18 months longer than children who remained in the at-risk range.

The medical, dental, and mental health care needs of both children and families are addressed through a coalition of community service agencies. A special emphasis is placed on assuring the provision of preventive health care services such as prenatal care, immunizations, well care exams, and dental screenings. All children born while their parents were enrolled in the CFP had normal birthweight for their gestational age. The percentage of children current with their immunizations, well care, and dental care consistently ranges between 70-90%. Adult mental health is screened using the Symptoms Checklist 90-R. Of those assessed 1) 52 mothers and 25 fathers were identified as within normal limits; and 2) 38 mothers and 24 fathers were identified as having mental health needs severe enough to warrant further assessment and/or treatment. Although the CFP has written agreements with eight agencies that provide mental health services, many families refuse these services. As a result, the CFP has taken an active role in providing home-based mental health services. The CFP provides a high level of home-based case management services.

Increases in earned income are an indicator of both economic and social gains. In the first 60 months of service 1) average family income increased by 264% from \$8,808 to \$23,292 per year (from 64% to 116% FPG); 2) fathers' income consistently ranged between 70-80% FPG; and 3) mothers' income increased from 15-40% FPG. The employment of fathers fluctuated between 80-100% while that of the mothers' increased from 35%-80%+. Significant changes in both mother and father income outpaced cost-of-living increases caused by inflation and increased family size. Seventeen GEDs/high school diplomas were completed; 11 are still active. Three college degrees were completed; 15 are still active. Twenty-eight vocational certifications and/or licenses were completed; eight are still active. In collaboration with community agency partners and families, the CFP has been effective in 1) increasing the healthy development of children and families; 2) increasing parents' basic skills and parenting abilities; 3) improving families' economic self-sufficiency; 4) improving adult education and skill levels; and 5) improving parents' ability to set and achieve goals, problem-solve, access community services, and become an integral part of their community.

The Impact of the Head Start Experience on Maternal Functioning at Home and in the Workplace: Implications for Welfare Reform

Louis Buffardi, Evelyn Slaght, Charlene Douglas, Carol Erdwins, Ruth Zambrana

Presenter: Louis Buffardi

For 30 years Head Start has been an invaluable resource for low-income parents of preschool children. The research on Head Start, understandably, has focused on the activities and learning of the children, with less exploration of its impact on the parent. Yet the considerable stress faced by these parents likely impairs their ability to instill the kind of social competence in their children that will make them productive members of society. In addition, the parents' desire and ability to maintain paid employment may be affected. The consequences of this latter consideration are substantial, particularly given the implications for welfare reform. To facilitate research on these issues, we are proposing a process model of the impact of Head Start on maternal psychosocial functioning.

Recent research indicates that for well educated, higher income mothers, satisfaction with their child care arrangement is multifaceted; further, these dimensions are significantly related to other aspects of the mothers' lives, including role stress, mental health, and satisfaction with and commitment to their work. Unfortunately, there are limited data on how low-income, ethnic minority mothers view day care for their children. Indeed, the Human Capital Initiative has highlighted the need for research on caregiving stress among ethnic minority groups and people living in poverty.

Our model hypothesizes that the mother's satisfaction with the child care provided by Head Start is central to understanding her well-being. Parental involvement in child care positively contributes to the mother's child care satisfaction and her self-efficacy, both of which in turn reduce the stresses of work-family conflict and role overload.

Support from the spouse/partner and employer are also proposed to reduce role stress. In turn, role stress is hypothesized to affect the mother's well-being, both in terms of general mental health and work-related attitudes, including job satisfaction and intention to remain in the work force. This last variable is particularly relevant to the current debate over welfare reform. For example, this model predicts that a mother who is dissatisfied with her child care will have more difficulty in balancing her work and family roles, which may raise her stress level to the point where she is less likely to remain in paid employment. Thus, Head Start efforts to provide satisfactory child care and develop the self-efficacy of parents may facilitate substantially Congressional attempts to reduce the welfare rolls.

The objective of our current research is to test the cross-cultural applicability of this model to Latino, African-American, and White low-income mothers. The value of a valid model of the impact of Head Start on low-income mothers cannot be overestimated, particularly for the design of successful interventions. If social scientists are to understand fully the complexity of these concerns in order to provide guidance to both practitioners and policymakers, then a fully-tested model of the process is essential.

Family Support and Self-Sufficiency

National Evaluation: Missing the Mark on Program Successes

Harriett D. Romo, Jonathan Engel

Presenters: Harriett D. Romo, Jonathan Engel

The Administration on Children, Youth and Families (ACYF) funded Family Service Centers (FSCs) to determine how effectively Head Start could address the interrelated problems of illiteracy, substance abuse, and unemployment. ACYF also funded a national evaluation of the FSCs with two goals: 1) to describe the process of implementing a FSC; and 2) to assess the impacts of a case-managed approach to adult education and job training. The national evaluation design required random assignment to treatment (FSC services) and control groups (regular Head Start). This paper, based on data from a rural FSC site in San Marcos, Texas, serving Mexican-origin families, discusses the national evaluation design and the outcomes the national evaluation failed to address.

A baseline and two follow-up questionnaires designed by Abt Associates provided data on Head Start parents' household income, work patterns, participation in literacy and job training, extent of substance abuse, contacts with case managers, health status, and use of public assistance. The CES-D and the CASAS literacy test were also administered. The local evaluator collected qualitative data based on in-depth interviews and home visits with a subsample of the families. Case studies illustrated self-sufficiency, family strengths, and adaptive strategies.

Overall, treatment-group parents participated in education and job training to a greater degree than control group families. The mean difference in participation was statistically significant [$t=-2.69$, $p=.01$ (two-tailed test)]. However, there were additional positive differences between the two groups that were not statistically significant and important weaknesses in the national evaluation design. First, the timeline imposed by the national evaluation created difficulties for practitioners. Projects funded in October could not begin delivery of services to families participating in the national evaluation until the following September. Second, families interested in literacy and job training were assigned to treatment and control groups by "lottery." Over time, this created negative feelings among the control group and also presented problems for active recruitment. Third, in a small community, random assignment resulted in relatives, co-workers, neighbors, and friends assigned to different groups. When FSC classes were not available to control-group families, the project projected an image of exclusivity and unfairness.

Fourth, local structural conditions, such as availability of jobs, public transportation, and child care were not taken into consideration in the evaluation of self sufficiency. Fifth, measuring the quality of case management services provided by the FSC against those provided by regular Head Start created friction between regular Head Start and FSC staff. Sixth, factors addressed in the request for proposals, such as collaborations with other programs, were not assessed in the national evaluation. The San Marcos FSC served as a catalyst for collaboration that resulted in increased services and sharing of resources. The positive impact on community relationships in adult education were not reflected in the national evaluation. Finally, attainment of self-sufficiency, English language and literacy skills, and improved job skills are long-term propositions. The two-year time span of the national evaluation was not sufficient to measure such changes. Families succeeded in numerous ways reflected in the case studies, but did not show statistically significant improvements in literacy skills, income, or self sufficiency. The process evaluation based on ongoing qualitative data collection allowed the FSC staff to continuously improve the program. The authors conclude that a treatment/control model may not be the most viable basis for evaluating service delivery programs or for determining allocation of scarce resources for children and families.

Collaboration of a Foundation, City Government, and Two Universities in the Design, Delivery, and Evaluation of a Family Support Program: Evaluation Design

David Lounsbury, Tom Reischl, Elizabeth Burki, Bertram Stöffelmayr

Presenters: David Lounsbury, Tom Reischl, Elizabeth Burki, Bertram Stöffelmayr

Four types of evaluation were conducted: process, internal, cost, and outcome. Both process and internal evaluation provided ongoing feedback to program administrators and implementors. Program costs and performance for the financial year 1995-96 formed the basis of the cost analysis conducted by Coopers & Lybrand.

Different evaluation strategies were pursued for the clinic-based arm (DFP) and community-based outreach (PPOP) arm of the Detroit-Skillman Parenting Program (DSPP). More than 3,500 families were served in the clinics by DFP. The DFP outcome evaluation was based on 500 families: 200 DFP participants, 150 minimal intervention participants, and 150 no-treatment controls. There was no appropriate control group for PPOP clients, so we therefore relied on a single group design. Two hundred PPOP clients were studied. All clients in the outcome evaluation were interviewed at the start of their involvement with the program and then at 4 months and 12 months thereafter.

The selection of measures for the outcome evaluation were based on extensive discussions with DSPP administrators and DFP and PPOP leaders and staff members. The client empowerment model on which both the DFP and PPOP program models are based implied an almost limitless range of interventions and therefore treatment effects. However, the written proposal as well as past experience of persons hired to conduct the intervention suggested a much more limited, albeit broad, range of interventions. To capture the range of possible DSPP treatment effects, we chose to cast a wide net of measures. The foci of all interventions codified in the curriculum were 1) parent/child interactions, including disciplinary practices; 2) family functioning; 3) parent psychological functioning; 4) parents' use of community services, including substance abuse and mental health treatment; and 5) parents' and children's use of medical services. We selected measures for all these domains, and added measures of health status, health service use, and health habits. Although neither physical health nor health service use were addressed directly in the workshop curriculum or the lesson plans for the individual counseling sessions, it was hypothesized by DSPP staff that program participants would learn more effective methods of interacting with the health care system, which in turn would result in better health. Only some health habits, such as substance abuse and the appropriate use of contraception (reflected in our measure of sexual responsibility), were regularly addressed by DSPP, whereas others, such as nutrition, exercise, and rest, were not.

Sociodemographic information was collected at intake and verified during later interviews. Family functioning, parenting practices and parent mental health, use of health services, and substance use and abuse were also assessed at each interview. All other measures were administered only at the 4- and 12-month follow-ups. At intake, all information necessary to describe families was collected, as well as measures of those aspects of family functioning, such as parent functioning and use of health services, that might be affected immediately by the intervention. Use of community and DHD resources, coping styles, and satisfaction with the program were assessed only at the 4- and 12-month follow-ups.

Family Support and Self-Sufficiency

Collaboration of a Foundation, City Government, and Two Universities in the Design, Delivery, and Evaluation of a Family Support Program: The Services Provided *Barbara*

Tripp, Diana Lawrence, Oliver Lindsay, Madonna Hudgens, Judith Maloy

Presenter: Elizabeth Burki

The Detroit-Skillman Parenting Program (DSPP) was a five-year-long effort to provide parenting education to families who attended Detroit Health Department (DHD) clinics or who requested help from the Public Health Nursing Service (PHNS). DSPP developed two intervention strategies: one designed to work with families in DHD clinics and another one to work with families in their homes. The Detroit Family Project (DFP), a unit of Wayne State University (WSU), operated at the clinics. The community outreach was accomplished by enhancing public health nursing's Para-professional Outreach Program (PPOP). The DFP, PPOP, and various support services were coordinated by the DSPP administrator.

Parent education and social support were the key components of the DSPP intervention. Workshops and individual counseling sessions within the clinics and home visits were the settings for the intervention. It is important to remember that families became involved with DSPP not because of an initial complaint related to parenting, but because families had attended clinics to resolve medical problems and approach Public Health Nursing Service for help with medical problems, or to obtain financial or other aid. DSPP interventions were superimposed upon medical and social services. The DSPP, irrespective of the setting in which the service was delivered, always dealt with parenting practices, disciplinary practices, child development, health care, and the effective use of community and DHD resources.

Parent empowerment was the guiding construct for DSPP. Both DFP and PPOP proposed to build on the client's strengths, rather than deficits. This strengths-based approach was not only meant to differentiate the DSPP intervention from a more traditional medically modeled intervention, but had implications for client recruitment and problem definition. In the traditional medical model, it is assumed that the client or patient will consult a service provider because of a complaint. The service provider and the client together will define the problem and decide on a course of action. The professional is involved in defining the problem and in deciding upon treatment or any other appropriate intervention. Under this model efforts are made to channel assistance to individuals and families with the most severe problems.

The strengths-based model, on the other hand, with its goal of patient empowerment, as pursued both by DFP and PPOP, places the responsibility for seeking treatment, and for deciding on the nature of treatment, on the client. That PPOP clients were self-selected for treatment is obvious: clients had to call 961-BABY to obtain services, but DFP clients also had to request services. Waiting rooms, workshops, and posters gave information about the availability of parenting classes and counseling sessions. Concern for client empowerment also led to the clients' active shaping of the curriculum: that is, the content of individual counseling or workshop sessions.

Delivery of Routine and Preventive Mobile Dental Services to Access-Problem Under-Served Preschool Populations *J. Edward Murphy, Carline S. Murphy*

Presenters: J. Edward Murphy, Carline S. Murphy

The importance of reaching these access-problem preschool populations with timely preventive and restorative dental services has been well recognized and documented since the inception of the Head Start program. Over the course of the last three decades, a combination of on-site delivery mechanisms and community referral-based efforts to facilitate the process of obtaining dental care for these children and increasing family awareness of dental health needs has been developed in the Head Start program. The process has demonstrated varying levels of success because of the strong dependence on patient compliance.

Except for those infrequent instances where preschools have had on-site, fixed dental operators, it has almost invariably been necessary for patients to seek outside consultants in office-based settings. Although this mechanism certainly prompted many children to seek care they may never have received without the program, logistical, physical, social, and economic barriers to care continued to prevent anything approximating universal access for this cohort.

Recent developments in portable dental equipment, and the staffing and organizational systems to support its use, have occurred to the extent that numerous access-problem populations will have a resource for comprehensive dental care in nontraditional delivery sites. This mode of delivery provides an option for policymakers to consider when designing logistically manageable and financially feasible delivery alternatives to insure optimal access to care for these patients at early age levels.

However, effective application of this mode of delivery requires a detailed awareness of the material and support barriers to care in these settings on the part of both clinical and administrative program coordinators, and defined measures to overcome these barriers, allowing treatment outcomes comparable with those expected in the traditional facility. Among these obstacles are task-appropriate equipment selection and instrument management, visiting and host staff inservice training and preparation, safe and efficient radiology in the nontraditional site, computerized logistical and patient record-keeping support for the mobile dental teams, and infection-control practice in the non-traditional setting.

Applications of comprehensive mobile dental services have been utilized successfully in various populations, including geriatric institutionalized, homebound, military combat units, large refugee populations, congregate elderly, and school sealant programs. Use of the mobile model of delivery translates well into school-age and preschool-age groups in school-based settings and can be equally effective for these groups. This is a viable alternative or supplemental option for delivery methods presently being utilized.

Advantages of utilizing such an approach include an almost universally predictable level of utilization, predictable delivery costs, and the minimization of many of the logistical, social, and administrative difficulties inherent in obtaining similar results within the present loosely structured referral-based system. This approach will insure delivery of basic primary-level dental services to these groups, ranging from basic dental prophylactic procedures to a more ambitious menu of services such as sealants or restoratives.

Interagency Collaboration: Head Start and a University School of Nursing

Marilyn Birchfield, Judith Scully, Paula Luszcz

Presenters: Marilyn Birchfield, Judith Scully, Paula Luszcz

Agency collaboration is gaining increasing importance for Schools of Nursing as health care changes emphasize the community as a major site for healthcare. Nursing faculty seeking community opportunities to prepare future nurses find Head Start of special interest as a model of comprehensive care for low-income families. The skill required in developing successful collaboration between agencies is often underestimated. Polivka identifies factors to consider in a conceptual framework for community interagency collaboration. When the goals of the two agencies are very different, for example, the education of student nurses versus the promotion of family functioning and child growth and development, the decision-making that occurs is defined by Polivka as mutual adjustment. Collaboration between the two agencies is limited to specific cases, such as the provision of health education and services. Successful collaboration is valuable costwise to Head Start, by increasing its services to families. To the School of Nursing, collaboration provides an opportunity for students to assess needs within a community program, plan interventions, and work with community professionals.

A successful example of collaboration between Head Start and our School of Nursing was the "Great American Smokeout Day." The students planned popular activities for the children, such as blowing up balloons and making soap bubbles as well as special songs for six of the children's classes; they planned workshops with the parents and the staff to discuss smoking and its effect on health, as well as how to stop smoking. Attendance at the parent and staff workshop was good, and there were many questions from the participants about their experiences, as well as methods found useful in lessening the need to smoke.

Because student groups are constantly changing (there are new 'rotations' every seven weeks), faculty need to become familiar with the structure of Head Start to provide an ongoing presence with the children and staff, and to inform new student groups about the purpose of Head Start and its components.

Collaborative interest declines quickly when planning for health programs is unsuccessful, for example, when there is no audience for students after they have worked hard to plan programs, when student teaching or skill in providing health care is inadequate as perceived by Head Start personnel, or when the activities planned for students are inappropriate. Faculty must always be aware that students are paying tuition to receive experiences that are educational or promote their caregiving skills. It is often difficult for personnel in both agencies to address these types of issues with each other. However, for collaboration to continue, the outcomes for both agencies must be evaluated, problems identified, and solutions sought. Both may have to re-examine whether they are able to meet each others' expectations. When the collaborative process is successfully negotiated, respect and enthusiasm for each other's program develops, as well as an eagerness to support each other.

An 'extra' outcome for both the University and Head Start is the orientation of young socially sensitive students to the role and mission of Head Start. As the students become involved with Head Start children, parents, and staff, they recognize the value of the comprehensive approach in promoting family health, and they learn that health promotion demands much more than traditional medical care.

Evaluation of a School Breakfast Program for Preschool Children

Harriet S. Worobey, Pedro Vieira, and John Worobey

Presenters: Harriet S. Worobey, Pedro Vieira, and John Worobey

After conducting a pilot project that suggested Head Start children ate more balanced breakfasts than children enrolled in private preschool and day care programs, we added a breakfast component to our existing laboratory preschool program that followed the guidelines of the School Breakfast Program (SBP). We were specifically interested in evaluating the nutritional impact of school breakfast participation upon the pre-academic performance of four year olds. During the fall of 1994, breakfast was provided to a subgroup of children prior to their usual school day. Breakfast menus varied across the program but were always in compliance with the SBP Guidelines. Baseline data on the children's breakfast routines prior to the start of the breakfast program were obtained, with concomitant measurement of performance on a battery of pre-academic and cognitive tasks. Six weeks after the inception of the breakfast program, food records for the children in the breakfast program were kept for two weeks, and parents of control children completed food records for breakfasts eaten at home. As during the baseline condition, performance on a parallel battery of tasks was measured for all children. The study was then replicated during the spring of 1995. Results indicated that the nutritional content of the breakfasts eaten at school was better than that of those eaten at home, and that children's performance on a number of pre-academic tasks was also enhanced under the school breakfast condition.

Stress, Health, and Immune Functioning in Young Children

Elizabeth K. Campbell, Megan R. Gunnar, Laurie Brodersen, Joseph Rigatuso

Paper not available

Recent advances have allowed non-invasive examination of immune functioning in children by assaying interleukin-1 beta (IL-1b) in saliva. The usefulness of salivary IL-1b for examining associations with illness and hormonal stress reactions in children was explored. A pilot study examined correlations between IL-1b and cortisol in a small sample of nursery school children. Two follow-up studies were then conducted, one with 65 children at an HMO clinic and one with 25 children in nursery school.

Toolkit for the Self-Assessment of Immunization Practices in Private Physicians' Offices

Veronica Elliot, Dale S. Kasab

Paper not available

Health and Nutrition

Project SIBS*: Evaluation of a Rural Immunization Program for Head Start Siblings

Brenda Stevens, Tom Hansen

Presenter: Brenda Stevens

National objectives for the year 2000 focus on increasing to 90% the number of children who have completed their primary vaccination series by two years of age and are defined as being up-to-date (UTD). This study looks at the effectiveness of an immunization program designed for the rural low-income family and the factors that influence effective health care service delivery. Subjects consisted of the 187 younger siblings of Head Start children from a 21-county area in the Midwest. The families of these children were provided with an information workshop, a child immunization clinic, information about local health clinics, free immunizations, immunization reminders, and reimbursement for transportation and child care, if needed.

The children's immunization dates and records were examined to determine if they were up to date (UTD), or not up to date (NUTD), at one year of age and two years of age. At the beginning of the study and prior to the intervention program (PRE), examination of immunization records indicated that only 60.0% of the children were classified UTD at one year of age and only 58.7% were classified as UTD at two years of age. By the end of the intervention program (POST), 91.3% of children who were less than seven months old at the beginning of the study were classified as UTD by age one. Similarly, by the end of the intervention (POST) 88.9% of children who entered the program at age one or younger were classified UTD by two years of age. Chi-square analyses confirmed significantly higher UTD immunization rates in POST versus PRE groups both at age one ($X^2 = 7.164, p < .01$) and at age two ($X^2 = 7.522, p < .01$).

Results indicate that the intervention program produced a significant increase in the percentage of children receiving timely immunizations, resulting in a level close to the national goal of 90%. Innovative mechanisms and collaborative models were used to train personnel, track immunizations, evaluate program effectiveness, and increase service delivery. Findings support the notion that such interventions may successfully influence receipt of medical services by low-income rural populations of children.

Preschool Asthma Education Project *Jeanne McBride, Suzanne Steinbach*

Paper not available

The Preschool Asthma Education Project aims to reduce the excess morbidity experienced by very young children. The Project goal is to reduce asthma symptoms, absences, and need for emergency treatment by providing Head Start-based asthma education and support, enabling families to adopt improved management strategies and enhance preventive asthma care.

Determinants of and Attributions for Physical Activity Behavior among African-American Parents of Head Start Children

Darren C. Treasure, Curt L. Lox, Betty Lawton

Presenters: Darren C. Treasure, Curt L. Lox, Betty Lawton

A paucity of research evidence is available directly addressing the physical activity behavior of low-income African Americans who make up more than 36% of the enrollment of Head Start. The purpose of this study, therefore, was to examine possible determinants of physical activity in African-American Head Start parents in St. Clair County, Illinois. Difficulties with data collection, however, resulted in the decision to conduct a second study assessing the originally proposed variables in a more controlled context. The sample consisted of 30 Head Start employees based at the East St. Louis Center, Illinois. Participants ranged in age from 29 to 66 years of age ($M=46$ years) and consisted of 24 females and 6 males. Participants underwent a physiological assessment consisting of Resting Heart Rate (RHR), height and weight, Sub VO_2 , and abdominal strength. Upon completion of the physiological assessment, the participants completed a battery of questionnaires. Participants' level of physical activity was assessed using the Physical Activity History Questionnaire (PAH). Information concerning education level, income, age, and gender, which have been shown to discriminate physical activity rates in previous studies with White populations was collected. In addition, the Physical Self-Efficacy scale of Ryckman et al. and 13 items reflecting barriers to adherence to physical activity were presented.

As proposed by Jacobs et al., it is important to relate self-report information to the variables of interest to directly validate a measure. To this end, the correlation between various physiological measures and scores from the PAH suggests that this brief self-report assessment was a valid measure of physical activity in this instance. Specifically, higher levels of PAH were found to be related to lower body-mass index, higher abdominal strength, greater sub VO_2 max., and a lower RHR. As the PAH and physiological data were assessed at the same time point, it prevents any speculation as to the causal pattern of relationship between these variables. In addition, a conceptually coherent pattern of relationships emerged between PAH and the psychological and demographic variables. In this case, physical activity was positively related to perceived barriers, perceived physical ability, and education level. A negative correlation between gender and physical activity also suggests that males were more active than females in this sample.

Similar to previous research, results from a logistic stepwise regression procedure revealed that education level and confidence in one's ability to overcome perceived barriers to exercise discriminated between more and less active participants. In addition, the predictive variables improved the correct classification of participants as more or less active by 20%.

It is the contention of the authors that promoting physical activity as a primary health care modality through educating parents would significantly impact the health and welfare of the Head Start community. The long-term goal of this project, therefore, is to design intervention programs to enhance physical activity within the Head Start African-American community. Before any strategies can be developed, however, our understanding of physical activity behavior must be enhanced.

Leading the Way: The Importance of Formative Research in the Development of Public Health Materials *Marsha E. Williams, Beth A. Richman, Elise Cappella*

Presenters: Elise Cappella, Beth Richman

Children's Television Workshop (CTW), producer of "Sesame Street," "Ghostwriter," "Square One TV," and other educational multimedia projects, has gained recognition for the highly collaborative model of development that shapes all of its television series and outreach efforts. While the production team is responsible for the aesthetic presentation of the material, and the content specialists oversee the educational agenda, it is the responsibility of the research group to represent the needs, developmental status, and perspective of a project's intended audience. Through ongoing formative evaluation, CTW's researchers inform the development of television series, print, and community outreach materials in critical ways.

This paper presents the "Sesame Street Lead Away!" Lead Poisoning Prevention Project as an example of the importance of formative research in the development of public health materials. With 1.7 million American children under the age of six adversely affected by exposure to lead, lead poisoning has been cited by the Centers for Disease Control and Prevention as one of the most common pediatric health problems today. In response to the need to educate preschool children, families, and caregivers about this critical issue, the Prudential Foundation awarded over one million dollars to the National Safety Council's Environmental Health Center (EHC) and CTW to develop a multiple-media national public awareness and prevention campaign.

The "Sesame Street Lead Away!" Lead Poisoning Prevention Project includes a videotape and audiotape for preschool children, as well as a comic-book-style brochure and user's guide for parents and other caregivers of young children. The audiotape and the print components are available in both English and Spanish. Fifty thousand sets of materials are being distributed free of charge through networks such as child care centers, community organizations, health care providers, and public health organizations.

Formative research was conducted at each phase of this project's development in order to ensure that the needs of the target audiences were being met and that the materials were as entertaining and educationally valuable as possible. The research was designed to 1) gather information from context experts at the start of the project; 2) explore the appeal and comprehensibility of a rough draft and near-final version of the "Sesame Street Lead Away!" videotape among preschool children; 3) explore the appeal and comprehensibility of draft versions of the English- and Spanish-language audiotapes among preschoolers; and 4) explore the appeal, comprehensibility, and potential use of draft versions of the English- and Spanish-language brochures among parents and other caregivers of preschool children.

The challenge in developing the "Sesame Street Lead Away!" Lead Poisoning Prevention Project was to increase awareness of the dangers of lead poisoning and to stress effective preventative measures. In facing this challenge, the research team provided practical, specific feedback that improved the quality of the project. This multiphase program of formative research gave producers a glimpse of the ways in which the target audiences might receive, process, and understand the important health messages. This responsiveness made formative research invaluable to the development of appropriate, appealing, and effective health education materials.

Effects of an Intervention with Substance-Abusing Women and Their Infants from Birth to 18 Months Postpartum *Maureen Schuler, Prasanna Nair*

Presenter: Maureen Schuler

The purpose of this study is to evaluate the effectiveness of a comprehensive intervention with substance-abusing women and their infants on infant development and maternal parenting. As part of an ongoing, longitudinal randomized study, 296 substance-abusing women were recruited from the University of Maryland Hospital at delivery. Mothers and their infants are seen for clinical evaluations at two weeks, and at 6, 12, 18, and 24 months postpartum. At the end of the two-week visit, the mothers and their infants are randomly assigned to the control or intervention group. In the control group, mothers receive monthly home visits by an outreach worker in an attempt to reduce attrition. In the intervention group, a parent advocate makes weekly home visits to the mothers during the first year, and during the second year, the mothers and their infants receive a comprehensive center-based parent intervention two days a week.

Group comparisons between the intervention and control families reveal that there are no significant differences on any maternal or infant demographic variable at entry into the study. The mothers are mostly low-income, single and African American. At the two-week clinic visit, mothers in both groups report higher levels of depression than the normal population. Preliminary analyses indicate that during the first 18 months, infants in both groups are scoring within the normal range on the Bayley. At all the visits, mothers in both groups are similar in their reports of drug use, stress, social support, and infant temperament.

Previous research indicates that prenatal substance abuse may have indirect effects on cognitive development. Further analyses will be done to determine if there are more subtle group differences. Mothers and infants in both groups continue to live in chaotic environments. Longitudinal research with substance-abusing women is needed with the understanding that simple main effects may be unlikely in early infant development.

Infant Mortality in the District of Columbia: A Program to Address the Problem through Improved Parenting and Health Care Utilization

Marian H. Jarrett, Linda Diamond, Michal Young, Mehrur Abedin

Presenter: Marian H. Jarrett

Pride in Parenting is a community-based research project for high-risk mothers and their infants in the District of Columbia. The project is a collaborative project between nine institutions in the city. Mothers who have had little or no prenatal care are recruited at the time of birth from one of four area hospitals. Each mother completes a series of baseline questionnaires at the time of recruitment and again during a 12-month evaluation where an assessment of infant development is also performed.

The mother-infant dyads are randomly assigned to an intervention or control group. The control mothers receive regular social services throughout the first year of the infant's life. The intervention group receives a weekly home visit for the first four months and biweekly visits from month 5 to 12. Beginning at month five, a biweekly group session is added to the intervention program.

Each group intervention is one and one-half hours long. The mothers and babies are together for the first 45 minutes in the Developmental Play Group. The group intervention focuses on improving the quality of mother-infant interaction and helping mothers enjoy their children. Information about infant development is discussed, and mothers have a chance to play with their infants in ways that facilitate age-appropriate skills. Group lesson plans are both original and adaptations of the Developmental Play Group Guide by Browne, Jarrett, Hovey-Lewis, and Freund.

During the second 45 minutes, the mothers move into the Parent Support Group while the infants are cared for by the project staff and volunteers. The Parent Support Group serves to reinforce the developmental concepts presented in the mother-infant play group. It also provides a forum for discussion and delivery of information about health, social support, and issues raised by the mothers. The Parent Support Group lesson plans are original, drawing from several sources, including *Parentmaking* by B. Annie Rothenberg. The groups continue until the baby is one year old.

Early Check: A Home Visiting Template for Early-Intervention Collaboration in Rural Communities *Michele Strobbridge*

Presenter: Michele Strobbridge

A rural Head Start program, in collaboration with the local Public Health agency, is implementing a home visiting program for multistressed families with children aged birth through two who may be developmentally at risk. Program characteristics include: a 10-family case load; weekly home visits of 90 minutes; a registered nurse case manager; family-directed services; and intensive support from a multidisciplinary team. This is a two-year demonstration grant funded by the state's Department of Health Early Intervention Program.

The poster presentation identified features that characterize the multidisciplinary, transactional approach of the program. The program incorporates the following components: health, child development, social services, family development, interagency collaboration, and consultation services from a family psychotherapist. A weekly home-visiting schedule depicted when Individual Family Service Plans are reviewed, daily meetings with supervisors are held to discuss progress and concerns, and time is allocated for documentation.

After a year and a half of implementation, the following lessons were learned: 1) provide for ongoing, focused staff training with time for analysis of program implementation; 2) have a licensed psychotherapist as part of the team to work with the staff and provide insight for a particular intervention, brainstorming challenging situations, meeting individually with parents, and assisting with the program evaluation; 3) have regular reviews of program goals with families as one way to keep the process of change in focus, as well as emphasizing the roles and responsibilities of the family, child, and community; 4) build in enough money for a variety of respite care settings for parents and children; 5) insure supervisor is registered nurse with a public health and human service background; 6) provide consistent mentorship; and 7) maintain an ongoing dialogue with community agencies to establish a family-services support network.

The Home and the Family as the Context for Caregiving: A Nurse Home-Visitation Program Perspective

H. Lorrie Yoos, Harriet Kitzman, Robert Cole, David Olds

Presenters: Unable to attend

There is a growing national interest in promoting home-visitation programs to improve the health and development of at-risk socially disadvantaged women and children. While randomized trials that tested the effects of diverse types of home visitation have increased our knowledge of some of the structural factors necessary to achieve positive results, we know much less about the process factors involved in successful programs.

Much of the current debate about welfare reform is focused on how to help low-income mothers of young children break out of the cycle of poverty and welfare dependence. We propose that unless intervention programs identify and attend to the beliefs and priorities of the participants, as well as the contextual and process factors involved in actual program delivery, the impact of programs will not be optimized.

We conducted a qualitative research project in order to examine the process of intervention program delivery and to inform the interpretation of the outcomes of the Memphis New Mothers Study, a large-scale randomized trial that assessed the effectiveness of a nurse home-visitation program on the outcomes of pregnancy, infant health and development, and women's decisions to remain in school, find work, and plan future pregnancies. These issues were addressed through a combination of education, goal setting, problem-solving, enhancement of informal social support, and linkage of families with needed services.

Our goals were to 1) explicate the issues/dilemmas of program delivery; 2) describe the social contexts in which these issues/dilemmas were embedded; and 3) identify the strategies the nurses used as they carried out the intervention with a high-risk population of families.

The nurses provided detailed narratives, on a monthly basis for approximately two years, of the experience of providing an intervention program. They gave a rich description of the physical and social environment in which the participants lived, information concerning their assessment of family needs and progress, the intervention activities at each visit, and the families' responses to these activities. The nurses also depicted differences between the intervention program's and the mothers' beliefs and priorities in the areas of parenting and life-course development, and how these differences were negotiated.

Analysis consisted of identifying the descriptive and analytic categories, patterns, and themes that captured the interactions between the nurses and families over time and placing them within broader cultural and social contexts. Common issues in program implementation that were identified by the nurses were 1) becoming and remaining welcome in the home; 2) limits imposed by the physical environment; and 3) impact of the social environment. Dilemmas for the nurses included decisions around the following: 1) primary prevention versus secondary prevention activities; 2) "doing for" versus "teaching how"; 3) maternal life-course objectives versus child outcome objectives; 4) future orientation versus present orientation; and 5) cultural differences versus problematic behavior. Strategies for dealing with the dilemmas on the part of the nurses and the families were identified and discussed. Issues that have particular policy implications are highlighted, and recommendations are made regarding program development.

Preschool Participation: An Exploration of Factors Related to Preschool Participation Rates

Diane Schilder, Steve Machlin

Presenter: Diane Schilder

In recent years, policymakers have considered expanding Head Start and other Early Childhood programs to serve more children. Specifically, some have proposed expanding Early Childhood programs to serve more preschool-aged children, to better target underserved preschool-aged children, and to serve infants and toddlers. The discussion over expanding these programs has led to an interest in research on the demographic characteristics of children participating in preschool, the demographic characteristics of infants and toddlers, changes in the numbers of children living in risk groups, and the characteristics most likely to predict preschool participation.

To address these areas of research interest, the authors of the paper conducted a number of separate analyses. This paper represents a synthesis of these separate studies. The methodology used in the studies was to analyze the 15.2% sample of the decennial census to determine the demographic characteristics of preschool-aged children and infants and toddlers, the demographic changes that occurred between 1980 and 1990, and the factors most likely to predict preschool participation. The data were analyzed to determine the number of infants and toddlers and preschool-aged children living in the following risk groups in 1980 and 1990: poverty (as defined by the Office of Management and Budget), near poverty (defined as eligible for the federal Women Infants and Children Program), linguistically isolated household, immigrant family, family where no parent works, family where neither parent has a high school diploma, single-parent family. The authors also conducted a regression analysis of the sample of preschool-aged children to determine the factors related to preschool participation rates.

The analyses showed increases in the number of infants and toddlers and preschool-aged children living at-risk between 1980 and 1990. Specifically, the numbers of children living in poverty, near poverty, linguistically isolated households, immigrant families, families where no parent works, and single-parent families increased. Further, infants and toddlers were slightly more likely to be in the risk groups than preschool-aged children. The poverty rate for infants and toddlers and preschool-aged children living at-risk was 20%, and high percentages of these children lived in other risk groups. The results of the regression analysis showed that family income and education level are the strongest predictors of preschool participation. Some factors that are seen as "risk factors" for older children—living in a single-parent family and being a member of some minority groups—are associated with children's increased likelihood of preschool participation.

Effects of Low Birthweight and Early Intervention on Achievement Scores

Holly A. Hollomon, Keith G. Scott, Eleanor Levine

Presenter: Holly A. Hollomon

The Infant Health and Development Program (IHDP) was a multisite, randomized clinical trial that tested the efficacy of early intervention with low-birthweight (LBW<2500 grams), premature (<37 weeks) infants. From birth to age three, the Intervention group (INT) received pediatric follow-up, home visits, parent support groups, and a developmental curriculum. The Pediatric Follow-Up condition (FU) received pediatric and referral services only.

Studies have found that children born LBW score below their normal-birthweight peers (NBW>2500 grams) on tests of academic achievement. Therefore, NBW controls from the same geographic area as, and born within one week of the IHDP sample were selected. School records for the INT, FU, and NBW groups were located and updated yearly. The current study tracked the children at age nine and used the Stanford Achievement Test as an outcome measure.

Epidemiological methods were used to calculate the risk the LBW children had for poor achievement relative to the NBW referent group. Poor achievement was defined as the combination of children who were not testable due to placement in exceptional student education and those who scored below the tenth percentile on an achievement subtest. The children in the FU group had 1.43 times the risk of poor achievement on reading, 1.91 times on math computation, and 1.59 times on math application compared to the NBW group. The intervention group also had a slightly elevated risk of poor achievement on all three tests (1.25, 1.48, and 1.48 respectively) compared to the NBW group; however, the confidence intervals overlapped 1.0 in all cases, indicating lack of statistical significance.

The Relative Excess Risk (RER) was calculated to estimate the risk the children in a group had of being categorized as poor achievers above and beyond the risk associated with NBW children. The RER for the FU group was .43 for reading, .91 for math computation, and .59 for math application. The RER for the INT group was .25 for reading and .48 for both math subtests. By subtracting the RER of the INT and FU groups, the decrease in risk of poor achievement attributable to the intervention was found for each test. Thus, the intervention accounted for a decrease in excess risk of 18% on reading, 43% on math computation, and 11% on math application in low-birthweight, premature children.

Early intervention appeared to offset some of the risk associated with being born premature and low birthweight since the INT group was not as likely as the FU group to be categorized as poor achievers compared to the NBW group. Additional evidence supporting the effectiveness of the intervention was that the groups were consistently rank ordered from least to best performance as FU, INT, and NBW, although not all of the differences between groups were statistically significant. Thus, receiving intervention did not make LBW children equivalent to their NBW peers, but did give them an advantage over other children born low birthweight and premature.

Verbal Communication Skills in Rural Appalachian Infants *Margaret Fish*

Presenter: Margaret Fish

This research reports results of an assessment of the communicative skill development of a group of 15-month-old economically disadvantaged rural Appalachian children. Subjects were 94 infants and mothers participating in a longitudinal study of factors affecting stability and change in temperament and infant development through 15 months of age. In this sample, most families have poverty-level income, and only about half of parents are high school graduates. At 15 months, one outcome measure was the MacArthur Communicative Development Inventory/Words and Gestures (CDI), designed for use with 8- to 16-month-old infants. The CDI is a parent-report instrument that provides scores for the child's comprehension and production vocabulary as well as his or her use of communicative gestures. The two purposes of the study were 1) to assess early communicative skill development in a low-socioeconomic status (SES) rural sample; and 2) to explore infant, mother, and demographic factors that might predict individual differences in communicative skill development within this group.

Results from the CDI for this group were similar to those reported by Fenson et al. for children from predominantly well educated, middle-class families who constituted the normative sample for number of phrases understood, number of words understood, number of words produced, and total communicative gestures. Mean percentile scores for the four communicative skills scores ranged from 49.9 to 59.1, again suggesting little deviation from the norming sample and reliable reporting by the rural Appalachian mothers.

Family demographics, infant characteristics, and mother-infant interaction variables were examined as influences on 15-month communicative skills. Following preliminary examination of the relations between conceptually relevant variables and productive language (words produced and total communicative gestures), two discriminant function analyses were carried out. The rural Appalachian infants were correctly classified high or low in productive vocabulary (above or below the median) 78.49% of the time, a significant rate 56.98% better than chance, by a set of 10 variables. Among variables that most clearly distinguished between infants who were high and low in word production, more verbal infants were more likely to be firstborn, and also to have had minor perinatal risk and been less positive and socially responsive at four months, but more positive and socially responsive by nine months. Mothers of infants with larger productive vocabularies reported higher levels of social support prenatally, had higher occupational status, and more often provided contingent feedback to their infant during a challenging task. In the second analysis, infants were successfully discriminated as above or below the median in total communicative gestures 74.63% of the time, a significant rate 49.15% better than chance, by a set of eight variables. Infants higher in communicative gestures (including signaling, actions with objects, games and routines, and imitating adult actions) were best discriminated by having mothers higher in extraversion (positive emotions), occupational status, and marital satisfaction, and more likely to be working at 15 months. Infants using more communicative gestures also had fathers with more education. These results suggest some caregiving environment variables that contribute to early communicative ability and may also suggest infants who might benefit most from early intervention.

Quality of Infant and Toddler Center Care for Low- and Middle-Income Children

Margaret Burchinal, Carollee Howes

Presenters: Margaret Burchinal, Carollee Howes

While Head Start offers relatively good-quality child care to many low-income children, these children may experience less than good-quality care prior to Head Start because the quality of center-based child care appears to be poor to mediocre for many infants and toddlers in this country. This study documents the overall level of quality of infant and toddler care and examines the extent to which quality of infant care varies as a function of the proportion of children receiving public subsidies attending the center within a large, four-state study.

The Costs, Quality, and Outcomes Study, which began in 1992, involved a comprehensive examination of costs and quality of early childhood center-based care in four states with varying levels of child care regulation. Included in the study were Los Angeles County in California, the Frontal Range region of Colorado, the Hartford-New Haven corridor in Connecticut, and the Piedmont Triad area in North Carolina. A random sample of about 401 early child care and education programs (about 50 for-profit and 50 nonprofit per state) was randomly recruited and visited in the spring of 1993. The study included only state-licensed child care centers offering year-round care. They had to have been in operation for at least one full fiscal year, and the majority of children had to attend at least 30 hours per week. Data collected included extensive interviews with the center director and classroom teachers, questionnaires completed by center staff, and observations of infant and preschool classrooms. An extensive interview with the director involved questions about program characteristics, including the number of subsidized children and the education, training, demographic characteristics, and wages of each staff member working directly with children.

Two classes were observed in each center. An infant or toddler classroom and a preschool classroom were randomly selected when possible. A pair of observers visited each center for one day between 8:30 a.m. and 3:00 p.m. to observe the two randomly selected classrooms. They completed the Infant/Toddler Environment Rating Scale (ITERS), the Arnett Caregiver Interaction Scale (CIS), and the Howes and Stewart Teacher Interaction Scale (TIS) and Peer Play Scale. The ITERS measure the overall quality of the classroom by asking about the personal care routines, fine and gross motor activities, creative activities, social development practices, and adult needs. The CIS measures the lead teacher's sensitivity in interactions with children while the TIS measures the amount and quality of teacher-child interactions.

Of the 401 centers, 154 included assessments of infant or toddler classrooms. The proportion of children receiving subsidies at each center varied across these centers from 0-100%. However, this proportion was not uniformly distributed. The centers were grouped empirically into centers with fewer than 33% of children receiving subsidies ($n=121$), 33-66% receiving subsidies ($n=16$), and 67-100% receiving subsidies ($n=17$). These three groups were compared on our process and structural measures of quality. Examination of the measures of quality indicates that many of the centers are providing relatively poor-quality care according to the ITERS, but have lead teachers who are relatively sensitive (3 on a 4-point scale), spending between one third to one half of their time being at least minimally responsive to the children.

Significant comparisons emerged only in analysis of the structural measures, not the process measures. Group differences emerged on the adult-child ratio, the proportion of lead teachers with at least an AA degree in Early Childhood, the wage paid to lead teachers, the total enrollment of the center, and whether the center was a for-profit or nonprofit center. Significantly

better adult-child ratios, better teacher wages, and smaller enrollments were observed in the 17 centers that predominately served low-income children. Most centers that did not serve low-income children were for-profit centers, while almost all centers serving a moderate to high proportion of low-income children were nonprofit centers.

These preliminary analyses indicate that infant and toddler care is of poor to mediocre quality according to one measure of quality (ITERS), but better according to another standard measure (CIS). Most comparisons were not significant, indicating that centers that predominantly serve low-income children do not provide substantially poorer or superior quality care. However, important differences emerged on key structural measures such as adult-child ratio and teacher training. These results suggest that low-income infants and toddlers may be experiencing child care that is lower quality than Head Start, but not lower quality than their middle-income peers.

The Infant Health and Development Program: Linking Post-Intervention Service Use and Development

Tama Leventhal, Judith Smith, Cecilia McCarton, Marie McCormick

Paper not available

The links between service use (medical, educational, psychological) and child development following participation in a comprehensive intervention are explored in this study. Child and family characteristics and other factors associated with service use are investigated. The sample includes 985 five-year-old children who were born low birthweight premature and participated in the Infant Health and Development Program. Preliminary results suggest that for medical and educational services, children of less educated mothers and African-American children are less likely to receive services, despite poorer developmental outcomes. Psychological services are appropriately distributed among children most in need of these services. In addition, intervention effects were found for receipt of these services.

Protective Factors in the Content of Prenatal Care Services That Promote Normal-Birthweight Deliveries among African-American Women *Melva T. Covington*

Presenter: Melva T. Covington

Infant mortality and low-birthweight rates for African-American infants are twice as high as for White infants. One strategy to understand these excessive rates is to examine the differences in prenatal care services rendered within a given population of African-American pregnant women.

This analysis examined variations in prenatal care services given to African-American women. The 1988 National Maternal and Infant Health Survey, conducted by the National Center for Health Statistics, was used to identify the antenatal services, utilization patterns, and maternal risk status of 3,905 women. A retrospective case-control analysis was conducted that identified women who delivered normal-birthweight (NBW), moderately low-birthweight (LBW), and very low birthweight infants. Chi-square and logistic regression techniques were used to examine the differences in prenatal care services received by women while controlling for 18 selected low-birthweight risk indicators.

The results of the analysis indicate that no group differences existed in the proportion of women who received six core obstetric procedures and health promotion advice as recommended by the Expert Panel on the Content of Prenatal Care report in 1989. Women who received adequate care were more likely to deliver NBW infants than women who received inadequate care. Women who attended childbirth classes were more likely to have NBW infants than nonattendees. Women who participated in WIC were generally protected from having LBW infants; however, the degree of protection varied by income and public aid status. Women who reportedly received health promotion advice, adequate care, and attended childbirth classes were also significantly more likely to deliver NBW newborns than women who did not receive these combined services.

There were tremendous variations in how women accessed care and the content of prenatal care services that they received. Strategies that increase the use of antenatal services can lead to improved birthweight. Comprehensive care appears to promote NBW deliveries in this group of women who were at higher overall risk of delivering low-birthweight and premature infants. Adequate care, health education, and health promotion advice during pregnancy can promote NBW delivery.

Attachment in a Mexican Origin Population *Marlene Zepeda*

Paper not available

Preliminary data regarding variability in attachment relationships in Mexican-origin first-time mothers and their 12- to 13-month-old infants is reported. Also stress and social support are examined. Results suggest that the more low-acculturated/low-income mother experiences higher levels of stress and lower levels of social support.

Early Communicative Behavior: The Impact of Maternal Ethnicity, Substance Abuse, and Child-Rearing Beliefs

Helen L. Johnson, Anabel Bejarano, Barbara Nusbaum, Tove S. Rosen

Presenter: Anabel Bejarano

This report utilizes data from The Mother-Infant Study, an ongoing federally funded study of the neurobehavioral development of infants born to women living in poverty, two thirds of whom abused crack and/or cocaine during pregnancy. The study population is split fairly evenly between African Americans and Dominicans. Findings were based on the first 48 dyads to have data available at both the 6- and 18-month assessments; this subsample included 25 African-American (12 substance abusers, 13 non-abusers) and 23 Latino (11 substance abusers, 12 non-abusers) dyads.

We examined the relation between maternal ethnicity, substance abuse, and child-rearing beliefs and the child's early communicative behavior. Maternal beliefs were measured with the Concepts of Development Questionnaire (CODQ), administered at the six-month visit. The CODQ assesses the level and complexity of parents' thoughts about the processes underlying development. Scores characterize parents' thinking as either categorical, emphasizing single causes and permanent characteristics (e.g., "An easy baby will grow up to be a good child") or perspectivistic, acknowledging multiple and reciprocal influences (e.g., "Children's problems seldom have a single cause"). The child's communicative behavior was measured with subscales from the Parent Child Observation Guides (PCOG), used to code caregiver-child interaction at 18 months. The PCOG examines the extent to which the interactive behaviors of caregiver and child support the development of mutual competence.

In this study population, neither maternal ethnicity nor maternal substance abuse had a significant effect on the child-rearing beliefs measured by the CODQ. The groups did not differ significantly in either categorical or perspectivistic scores, and both sets of scores were quite low. The low level of responsiveness to the items suggests that for the study population, whose day-to-day existence is characterized by violence, frequent moves, and crowding, the child-rearing issues tapped by the CODQ are not a priority; there are more pressing survival issues to consider.

The main effects for maternal ethnicity and substance abuse also were not significant for children's ratings on the involvement with parent and language with parent subscales of the PCOG. However, the interaction between ethnicity and substance abuse was significant ($f = 4.10$, $p < .05$). In African Americans, scores were higher for children of substance-abusing versus nonabusing mothers ($X = 4.5, 3.0$, respectively), while in Latinos, scores were lower for children of substance abusing versus nonabusing mothers ($X = 3.85, 4.33$, respectively). The greatest difference occurred on the language with parent items. Results of a multiple regression analysis indicated that neither maternal ethnicity, substance abuse, nor CODQ scores explained a significant amount of the variance in the PCOG scores. The absence of effects may indicate, as suggested by the significant interaction, that these factors are operating differently within the two ethnic groups. However, the small sample size makes it difficult to adequately evaluate this possibility.

Project BEGIN: An Early-Intervention Research Study

Camille Smith, Ruth Perou, June Holstrom, Carol Boussy

Presenters: Ed Brann, June Holstrom, Ruth Perou

The preschool years of life are crucial for brain growth, learning, and development. During these years, brain development is vulnerable to long-lasting environmental and social influences. Children raised in environments with limited access to developmental stimulation and support are at increased risk for developmental delays. The National Educational Goals Panel reported that nearly half of the nation's infants and toddlers confront one or more major risk factors: inadequate prenatal care, isolated parents, substandard child care, poverty, and insufficient stimulation. Thirty-five percent of American kindergarten children arrive at school unprepared to learn. Research has shown that developmental delays associated with these socioenvironmental risk factors should be largely preventable.

In the course of more than a year's worth of discussions with a large number of individuals and organizations who maintain a strong interest in the development of America's upcoming generation, we found a remarkably consistent desire to move the field of early childhood intervention forward. We also found a remarkably wide variation in ideas on how to accomplish this goal. The coming year will be used to conduct an interactive and deliberative process to discuss and define a research agenda that meets the following three criteria: 1) strong scientific justification for the approach to improving developmental prospects for children; 2) high-quality research design, implementation, and evaluation; and 3) sufficient societal support for the research agenda. We believe that the near future presents the opportunity to reach a consensus within limited areas. Our target is to make progress toward that consensus.

There is a continued need for solid scientific research on societal or community interventions that benefit young children and their families. It is important that these research efforts be long-term longitudinal studies. There is also a need for concurrent cost-benefit data collection and comprehensive process evaluation. The CDC, as the nation's prevention agency, is in a unique position to carry out this study. The CDC has no plans to run an early-intervention program; therefore, the intervention research will be performed by a neutral organization.

Project BEGIN is a high-quality scientific study of early interventions conducted during the preschool years with the intent of improving the developmental outcomes for young children and their families. BEGIN early intervention refers to a variety of programs and services directed at children and/or their families to prevent or remedy a wide variety of developmental delays or problems. The CDC has joined with local research partners in multiple communities throughout the United States. Our local research partners will coordinate with existing community resources and services to conduct the study.

The research goal of this study is to provide scientific data for state and national policymakers and providers of services for young children and their families in order to determine 1) interventions that are effective to promote child development; 2) characteristics of children and families who benefit most from the intervention; 3) whether particular subgroups of children or families differ in their response to intervention; and 4) the costs and benefits of intervention.

Very Early Kangaroo Care Beginning at Birth for Healthy Preterm Infants and Mothers Who Choose to Breastfeed: Effect on Outcome

Gene Cranston Anderson, E. Brigitte Sylfrett

Presenters: Gene Cranston Anderson, E. Brigitte Sylfrett

Extrauterine adaptation for preterm infants is complicated by their physiological immaturity. Care of these infants varies in the United States. Feeding may be scheduled bottle feeding of specific amounts or scheduled or demand breastfeeding followed by bottle-fed supplementation to satiety. Some infants may be cared for in incubators. If preterm infants remain healthy, they may receive the same care as that provided fullterm infants. Another method of care, Kangaroo Care (KC), involves maternal-infant skin-to-skin contact (SSC) with self-regulatory breastfeeding. This pilot randomized clinical trial was done to develop a protocol for providing early and virtually continuous KC and to justify a large future experiment by determining the extent of the effect of KC on temperature, breastfeeding, supplementation, and weight.

Eight infants (four KC and four control) were studied. The selection criteria were 34-36 weeks' gestation; appropriate weight for gestation; vaginal delivery; maternal desire to breastfeed; 7 or more Apgar at five minutes; and no need for respiratory assistance or intravenous therapy. All infants received SSC with their mothers at an average of 30 minutes (SD = 10) postbirth. Random assignment by minimization technique, using six stratification variables, occurred at one hour postbirth (60 minutes). Control infants received routine nursery care according to hospital protocol. Nurse researchers, who stayed near the infant, assisted KC mothers with SSC and on-cue breastfeeding. KC infants were held skin-to-skin by their mother or father an average of 84% (SE = 4.2%) of the time. The mean observation period was 47 hours (SD = 14), after which the mothers were discharged.

Control and KC infants were similar on gestation (34.5 weeks $\pm$ 0.5 vs. 35.0 weeks $\pm$ 1.0) and birthweight (2288 g $\pm$ 410 vs. 2326 g $\pm$ 144). Control infants compared to KC infants had lower axillary temperatures (36.7 $\pm$.05 C vs. 37.0 C $\pm$.06) and greater variability (-1.97 $\pm$ 0.26 vs. -2.76 $\pm$ 0.17), fewer breastfeedings/day (2 $\pm$ 2.6 vs. 12 $\pm$ 3.2), more by bottle (62 ml/day $\pm$ 3.9 vs. 0), more I.V. fluids (87 ml/day $\pm$ 72 vs. 0), more heel sticks (7.5 vs. 1.2), and more days to discharge (14.5 $\pm$ 9.1 vs. 3.8 $\pm$ 1.0). Weight loss per hour and percentage of birthweight lost were similar, even though KC infants had no supplement via bottle or I.V. Hospital stay for control infants averaged 3 days in the NICU-I, 5.8 days in the NICU-II, and 5.2 days in the newborn nursery. KC infants stayed in the newborn nursery as "growers" after maternal discharge. No KC infant was admitted to an NICU. KC infants stayed with their mothers until the mothers were discharged at approximately 36 hours postbirth; then the infants stayed in the normal newborn nursery. Only one control mother was able to breastfeed, whereas all four KC mothers rapidly developed a large milk volume, had no signs of engorgement, had no complaints of breast or nipple pain, and breastfed successfully.

Three mothers in each group could be located after one year, and dramatic differences in their infants were revealed during telephone interviews. For example, no KC infants needed antibiotics versus two control infants, no KC infants had allergies or asthma versus two control infants, no KC infants required rehospitalizations versus two control infants, and breastfeeding duration averaged 4.6 months for KC infants versus 2 months for controls. We can conclude that a feasible protocol has been developed for early and virtually continuous KC for lower risk preterm infants. In addition, data have been obtained to justify a large and/or multisite experimental evaluation of this promising method of care.

Infant and Toddler Resilience: Knowledge, Predictions, Policy, and Practice

Kimberly A. Gordon

Presenter: Kimberly A. Gordon

Resilience, being competent despite adversity, is a relatively new area of research. It is important because approximately one third of the population is at risk of encountering adversity, even as young children. The scientists involved in resilience research are making a number of interesting discoveries that contribute to a growing body of knowledge. This body of knowledge is important for policymakers who design programs that impact the growth and development of infants and toddlers. It is also important for professionals who care for infants and toddlers.

Resilience is the ability to thrive, mature, and increase competence in the face of adverse circumstances. These circumstances may include biological abnormalities or environmental obstacles. Further, the adverse circumstances may be chronic and consistent or severe and infrequent. In order to thrive, mature, and increase in competence, a person must draw upon all of his or her resources: biological, psychological, and environmental. Adversity comes from various sources and competence depends upon age and environmental context. For instance, a competent infant need only hold the attention of adults in socially acceptable ways and express annoyance and affection when appropriate. However, during toddlerhood, this same infant must use adults as resources, show pride in his or her accomplishments, engage in role play, lead peers, follow peers, and compete with peers. Therefore, resilience is a multifaceted phenomenon that changes with each developmental phase. Accordingly, a person who is resilient in one developmental phase may or may not be resilient in another developmental phase. Past research has uncovered personal and environmental characteristics that contribute to resilience during infancy and toddlerhood, and has also shown what infant and toddler characteristics are related to resilience in later life stages. This accumulated body of knowledge is informative to policymakers interested in the care and education of infants and toddlers.

Mothers' Perceptions of Internal Control, Health Promotion Behaviors during Pregnancy, and Infant Health Outcomes

Sony Sierra, Sharon Burke

Paper not available

Mother and child health has been targeted as an area for health promotion, disability research, and program development. Recently, maternal health locus of control has been linked to health promotion behaviors that could affect child health. A conceptual model was tested and explored of the relationships between mothers' perceptions of internal control over their children's health, self-care behaviors during pregnancy related to their own and their unborn child's health promotion, and the child's eventual health and development using a sample of mothers and their three-month-old babies in low-income urban communities from the Better Beginnings, Better Futures Project

Object Play as a Window on the Cognitive Competence of Low-Income, Prenatally Substance-Exposed and Unexposed Toddlers

Marjorie Beeghly, Grace R. Brilliant, Howard Cabral, Edward Z. Tronick, Deborah A. Frank

Presenter: Marjorie Beeghly

In this prospective study, the effects of prenatal cocaine exposure on toddlers' object play and socioaffective behavior during solitary and dyadic free play contexts were evaluated and compared to that observed in a demographically similar control group. One hundred thirty toddlers ($M=12.6$ mo.) and their primary caregivers from low-income, urban backgrounds comprised the sample. Subjects were participants in a larger ($n=200$) ongoing longitudinal study. Seventy-four percent were receiving public assistance. All toddlers had been full term and clinically normal at birth; 51% were male; 89% were African American. Fifty-nine percent had been exposed to cocaine in utero, and 41% were unexposed controls. In-utero exposure was confirmed by urine and/or meconium assay at birth. Cocaine-exposed toddlers were more likely to have been exposed prenatally to tobacco, alcohol, and marijuana and to have lower birthweights than unexposed toddlers. Exposed and unexposed groups did not differ significantly on child gender or maternal education ($M=11.5$ yr). Exposed toddlers were more likely to be in foster care than controls.

Toddlers' free play with age-appropriate toys was videotaped in two contexts: caregiver-child play (8 min.) and solitary play (8 min.). The order of the play contexts was counterbalanced across subjects. Toddlers were also given the Bayley Scales of Infant Development (BSID). All research personnel were masked to exposure status. Toddlers' object play behavior was scored in intervals of 10 from videotapes, using a 14-step developmentally graded scoring system adapted from extant systems in the literature. Object play categories ranged from undifferentiated object manipulation (e.g., mouthing) to elaborated pretend play. Children's social behavior (without toys), disengagement, showing/giving toys to the caregiver, positive affect, negative affect, and disregulated behavior were also coded. Inter-coder reliability was high ($M>.90$).

Children with higher BSID MDIs engaged in developmentally more mature forms of object play in both solitary and dyadic contexts (all $p's < .01$). Children's BSID scores were unrelated to exposure status. Results of mixed analyses of covariance (independent variables: exposure status, gender, context order, and context; covariates: child age, tobacco, alcohol, and marijuana) yielded no significant main effects of exposure status on object-play maturity, social behavior, or disengagement. However, exposed toddlers exhibited less positive affect during play, and their play maturity was more likely to be compromised following the removal of dyadic support compared to controls. All children produced more mature play, less negativity, and less disengagement when playing with the caregiver than when playing alone. Girls produced developmentally more mature play than boys regardless of exposure status. Foster care status was unrelated to play variables.

Results attest to the validity of using free-play observations as a developmental assessment context in low-income, largely minority samples. Findings also suggest that prenatal cocaine exposure has negative effects on toddlers' affective and self-regulatory behavior.

Inclusive Classroom Interactions of Toddlers Prenatally Exposed to Drugs

Mark F. Whitney

Presenter: Mark F. Whitney

The purpose of this study was to describe the nature and content of the social interactions of toddlers prenatally exposed to drugs and their non-drug-exposed peers. The setting was a campus-based inclusive early childhood program serving children from 18 to 36 months of age and their families. The subjects were 13 children between 18 and 32 months of age, identified as having been prenatally exposed to drugs. Ten of these children were referred to the inclusive toddler classroom from the waiting list of a school district's infant development program, and three were referred from the developmental evaluation clinic of a local hospital. In addition to those children identified as prenatally exposed to drugs, 23 children from a range of ethnic backgrounds were enrolled in the program and included in the study as a contrast group.

Twenty distinct behavioral categories were used to describe the classroom interactions occurring between drug-exposed and non-drug-exposed children as well as between teachers and both groups of children. One 10-minute sample of the child/child and child/teacher interactions of each participating child was videotaped within the first five weeks of the child's initial participation in the program. For the purpose of discussion, behaviors were grouped conceptually and included Directives (those behaviors that involve a command, order, or motion requesting action or information); Affiliatives (those behaviors leading to physical proximity); Supportives (those behaviors that help, comfort, or aid); Informatives (those behaviors giving or providing information); and Negatives (those behaviors that express negation or denial, or lack constructiveness or helpfulness).

Analysis of the quality and content of social interactions and interpersonal skills was done through the use of a frame analysis videotape recorder. Behaviors per child per minute were determined, and mean rates of behavior for each population (drug exposed vs. non-drug exposed) across each of the five conceptual groups and by type of communication dyad (target child to peer; peer to target child; target child to teacher; teacher to target child) were analyzed through a one-way analysis of variance with repeated measures.

Young children prenatally exposed to drugs were involved in significantly more Directive-type classroom interactions and Supportive-type classroom interactions than were the toddlers who were not exposed to drugs. It may well be that these children may behave in certain ways that necessitate a more direct style of interaction, particularly on the part of teachers. Likewise, they may have needed more praise, positive touch, direct assistance, physical direction, and general affirmation in the classroom. Such positive interactions may tend to help young children prenatally exposed to drugs persist at classroom tasks, maintain attention to teacher direction, and feel more successful within the demands of a group setting.

There were no significant differences in Negatives exhibited by the children prenatally exposed to drugs when compared with their non-exposed peers. This finding tends to contradict the image of a disruptive, disobedient, and out-of-control "drug baby" so often portrayed in the popular press. This positive finding suggests that young children prenatally exposed to drugs can be effectively included in classrooms with nonexposed peers, they can function in a developmentally appropriate early childhood environment, and they may not require the extent of structured intervention that has been proposed to keep their behavior under control.

Family Routines as a Predictor of Emergent Literacy Skills *Dionne R. Dobbins, Daryl Greenfield*

Presenter: Dionne R. Dobbins

Low-income African-American children have a higher rate of illiteracy than their peers and have a greater chance of suffering academically. Prior to formal literacy and language instruction, young children experience their first encounters with literacy within the context of the family environment. Thus, an investigation of aspects of the family environment thought to be related to literacy development is warranted.

Large research projects like the Head Start/Public School Early Childhood Transition Project cannot obtain in-depth information from each of the families in the project. However, the project is guided by Family Systems Theory, and family functioning is hypothesized to play a key role in the child's academic functioning. Families in the project were interviewed on various aspects of their lives. Adherence to family routines and adequacy of resources were two ways of measuring family functioning in the Head Start/Public School Early Childhood Transition Project.

The Miami site sought to understand the relation between the project's measures of family functioning and early literacy development in the high-risk population of African-American pre-readers. Eighty-four low-income African-American families participated in this study. The children attended kindergarten in four schools in the Miami, Florida, area and were all part of the larger Transition Project. As a part of an extensive parent interview, parents or guardians of the kindergartners responded to questions about adherence to family routines from the Family Routines Inventory and their adequacy of family resources from the Family Resources Scale. The children were assessed during two separate sessions at school on the following four areas of literacy and language development: print awareness, knowledge about story structure, letter identification, and vocabulary skill.

Separate multiple regression analyses were done for each of the literacy outcomes. The total scores from the Family Routines Inventory and the Family Resources Scale served as the predictor variables for each regression equation. A linear combination of the total scores from the Family Routines Inventory and Family Resources Scale accounted for almost 10% of the variance in letter identification skill and almost 8% of the variance in the sequencing task. The total score from the Family Routines Inventory, by itself, was a significant predictor of letter identification skill and the sequencing task.

These findings are consistent with ethnographic research by Teale and Taylor and Dorsey-Gaines that documented how children learn about literacy through their everyday experiences with their families. Although the Family Routines Inventory does not directly address family time specifically related to language and literacy learning, it does ask the parent about the daily happenings within the home. The results suggest that adherence to a set of known routines provides an indirect index of "family time" in which some literacy experiences may be fostered.

Effects of the Navajo Nation Transition Intervention on Navajo Children's Learning Opportunities and Literacy and Math Abilities

John R. Bergan, Fen Fen Li, Jason K. Feld, Cobbie LeBlanc, and Larry Curly

Presenters: John R. Bergan, Fen Fen Li, Jason K. Feld, Cobbie LeBlanc, and Larry Curly

As part of the National Transition Demonstration Project, this study examines the effects of the transition intervention on the opportunities to learn given to children in kindergarten, and, in turn, the effects of learning opportunities on the cognitive and social abilities of Navajo children. In recent years there has been an acceptance of the establishment of assessment techniques that link assessment to the planning of learning opportunities for children. However when assessment is linked closely to instruction, there is a danger that rather than producing changes in children's abilities, instruction will only alter performance on the specific tasks assessed. Two hundred thirty Navajo transition kindergarten children who had previously attended Head Start were involved in the study.

Participating children and families were geographically divided into either the control group or the experimental group. Both groups were assessed using the MAPS Developmental Observation Scales and the Woodcock-Johnson reading and math scales. Only the experimental group had access to the Child and Family Development Consultation Model. The transition staff provided consultation to teachers, assisting them in using the results of the assessments to provide learning opportunities appropriate to each child's developmental level. Consultation was also provided to families involving a wide range of social, educational, and health services.

Following implementation of the transition intervention, both groups were assessed a second time on the MAPS scales and the Woodcock measures. In addition, the teachers in both groups filled out a Classroom Learning Opportunities scale indicating the extent to which they provided learning opportunities in each of the knowledge areas assessed on the MAPS scales.

The results indicate that the transition intervention had a positive effect on children's learning opportunities and that learning opportunities influenced their abilities in literacy and math. Learning opportunities affected specific capabilities indirectly through their impact on overall math and literacy ability. The transition intervention had an impact on children's competencies that generalized beyond the specific capabilities that were measured.

The Role of Parental Beliefs in Predicting Home Learning Activities in Rural Head Start Children *Sandra Machida, Angela Taylor*

Presenters: Sandra Machida, Angela Taylor

This study examined the role of parental beliefs in predicting home support of learning activities in rural, White Head Start (HS) families. We know that parents act as primary educators of their children, yet we remain puzzled by what may help form parental beliefs that support home learning activities. Limited and inconsistent information exists about the effects of the child's gender and temperament on parenting attitudes and expectations. Specific temperamental qualities may be perceived by parents as more conducive to 'teaching' their children in home learning environments. The ravages of poverty and significant life events on parenting competence have been substantiated throughout the literature, but their role in altering parental beliefs about control over parenting (i.e., internal attributions of control) and about one's sense of competence (i.e., sense of self-efficacy in childrearing) is less clear.

For this study, we focused on the following factors as possible predictors of parent-perceived control and efficacy: child gender, child temperament, and recent stressful life events. Specific research questions were: 1) did child gender and temperament relate to parental beliefs about control over child rearing or parent self-efficacy; 2) were stressful life events predictive of variations in parental beliefs; 3) what was the role of parental beliefs (control and efficacy) in predicting self-reported behaviors that support home learning activities? Thus, parent beliefs about perceived control and parent efficacy were used as intervening variables between the child/family factors and support of home learning activities.

For this study, HS parents participated (N=59) from a rural community in northern California. The majority of the parents (75%) were White. Using path analysis, significant path links were found between parental beliefs and child/family variables. Parents of tractable children reported having a higher sense of parental efficacy, and in turn had more reports of home learning activities. By themselves, child gender, child temperament, and stressful life events were not correlated with support of home learning. Parental beliefs, specifically parent self-efficacy, acted as intervening variables between child and parent efforts. Parent beliefs about perceived control appeared to support parent efficacy but were not sufficient to act as an impetus for home learning activities.

Thus, temperament and a sense of self-efficacy were predictive of parent involvement in learning activities often associated with school readiness and school skills. Temperamental qualities are both genetically and environmentally caused. Helping parents understand typical, and often annoying, behavior of children may reduce parent perceptions of child misbehavior. In addition, helping parents understand that they play a critical role in the formation of the child's temperament and school competencies may also increase efforts toward parent involvement in learning activities associated with school readiness and school skills. Parental beliefs are among the many factors that may explain variations in home support of academic skills. In this study, parent beliefs about parental efficacy provided a window into how parents may view their role in providing home learning activities.

Literacy and the Home Learning Environment

Adding Little Books to a Home-Based Head Start *Christine McCormick, Jana Mason*

Presenters: Christine McCormick, Jana Mason

Previous studies determined that using Little Books as an add-on curricular intervention with academically at-risk children can help to develop the children's early literacy concepts and skills. Little Books were designed to be easy to read, reproducible at low cost, and to balance text with illustration. A brief and familiar story line supplies a meaningful context, only a few words appear on each page, and a simple picture matches the text. The classroom introduction and distribution of the books for children to read at home fosters interest in reading and an opportunity to develop emergent literacy skills. One concern about Little Books is whether these books discourage parents and children from reading other books. This is an important consideration in view of the value of hearing a variety of stories and discussing more complex stories with parents. This study evaluates parents' and teachers' reactions to Little Books and whether their use discourages other book reading.

The participants were 42 families of three- and four-year-old children who were enrolled in a home-based Head Start program in Saginaw, MI. Little Books were added to the existing early literacy program: a teacher-directed lending library of children's trade books and related teacher-developed activities for the parent and child to do together.

In September, parents were given a questionnaire regarding their child's interest in and knowledge of print and their support for literacy activities at home, including an estimate of the number of minutes per week spent reading to the child. The questionnaire was repeated in May with additional questions regarding children's Little Books and storybook use. Teachers responded to questions regarding their reaction to the Little Books in May.

Twenty Little Books were introduced to the children over the course of the school year, one every other week. Home-based teachers brought Little Books and other literacy materials and activities for their weekly home visits. Teachers coached as needed when parents introduced a Little Book to the child and then gave the book to the child to color, keep, and reread. Children's use of the Little Books averaged 2.5 times per week and did not reduce the amount of time parents read to their child. Reading other children's books did not decrease with the addition of Little Books. Teachers and parents strongly supported the program addition of Little Books. Of the 22 parents involved in the program all year, all indicated they believed the Little Books helped their child.

Results indicate that a Little Books intervention is practical, appreciated, supports literacy development, and does not detract from the use of other children's books. Both parents and teachers indicated that Little Books are virtually self-explanatory, engaging, and readily used. The teachers have chosen to include Little Books in their home-based and center-based programs.

This study, in the context of previous research findings demonstrating ways to foster literacy, suggests that the Little Books could be a valuable (and inexpensive) component of an early literacy program in Head Start.

Emerging Narrative Skills: Low-Income Children's Interpretation of *A Boy, a Dog and a Frog* Margaret S. Benson and Holly J. Mohler

Presenter: Margaret S. Benson

Narrative is among those language skills that allow children to talk about that which is not "here and now," and is considered predictive of long-term school success. This study examines how children's understanding of psychological causation is related to their ability to produce goal-based episodes in narratives. Psychological causation refers to the attribution of causes to the internal states of characters, whether emotional or mental. There is evidence that children begin to talk about internal states and use these references to explain the psychological causes of behavior early in life.

Recently, Trabasso and Nickels asserted that psychological causation underlies children's ability to produce causally coherent narratives, as evidenced by an increase in goal-based episodes within a story. Benson also found that use of psychological causation is associated with more sophisticated levels of narrative structure.

In this study 34 children in prekindergarten and kindergarten were asked to "read" a wordless picture book, and the resulting stories were examined for the number of goal-based episodes included, and for the children's references to the internal states of characters. Nine children were pre-kindergartners (3 were still 4; 6 were young 5 year olds), and 25 were kindergartners (10 were older 5 year olds; 15 were already 6). All the participants were White, lived in a low-income neighborhood in an industrial city in Appalachia, and attended a Title I school. Participants were taken to a separate room and there they were audiotaped while reading Mercer Mayer's *A Boy, A Dog and A Frog* to a researcher. Transcriptions of the audiotapes were analyzed for attributions about the internal states of characters, use of psychological causation, and the number of goal-based episodes produced.

Kindergartners were significantly more likely to use psychological causation than were pre-kindergartners, who tended to use references to internal states simply as descriptions. Significant age differences were also found; four year olds were most likely not to refer to internal states, and six year olds were most likely to use psychological causation. Children who produced one or more goal-based episodes were significantly more likely to use psychological causation; children who did not use psychological causation were not likely to produce any goal-based episodes. There was no relationship between age and the number of goal-based episodes produced. Marginally significant differences between children in the two grades were observed.

The results indicate that these low-income children are beginning to produce goal-based episodes in a way that seems congruent with other research using middle-class samples. Further, it stresses how understanding human feelings, human motives, and the psychological causes of events underlies the production of goal-based narratives. Finding no difference by age is unusual, as in most research age is an important determinant of narrative ability. Recently, Frazier, Morrison, and Trabasso, using a middle-class sample, found that age was a better predictor of narrative ability than grade. This study hints at the opposite. The implication is that school experience may be more important for low-income children's development of narrative skill than it is for middle-income children's development of narrative skill.

Child and Adult Development in Low-Income Families Enrolled in Family Literacy Programs *Shelley M. Drazen, Mary Faust*

Presenter: Shelley M. Drazen

An effectiveness study of the Binghamton Even Start program was conducted by comparing participants in Even Start, an intensive home-visiting program designed to promote parent literacy and child development in highly disadvantaged families to a less intense similar program, PACT, which was shown to be effective in raising cognitive development and school performance in an earlier evaluation. The two programs are based in part on the national Parents as Teachers program, in which parents are taught that they are their children's first and most important teachers, given information about human development and how to facilitate it, and children are screened for developmental delays and referred to appropriate agencies when necessary. The programs are identical except that Even Start includes literacy classes for parents and parent-child literacy activities, whereas PACT does not, and Even Start offers more frequent home visitation, up to once a week, compared to once a month in PACT. Even Start families were significantly more disadvantaged than PACT families in the study: Even Start mothers had an average of under 10 years of education, compared to 13 for PACT mothers, and were significantly younger when their children were born. Three times as many Even Start families were on welfare compared to PACT families, and Even Start families included a much higher percentage of minorities.

Interim results indicate that for extremely disadvantaged families, the Binghamton Even Start program is highly effective in raising parent literacy levels and child cognitive development significantly over what would be expected due to participation in a less intense program. Parents in Even Start gained an average of about one grade equivalent in reading and two in mathematics skills, measured by the Test of Adult Basic Education [TABE], with many earning GEDs or high school diplomas in under a year of participation. Home atmosphere for learning, measured by the HOME Screening Questionnaire [HSQ], was also significantly improved. Even Start children gained an average of 10 months in language skills in an average of 5 months in the program, measured by the Preschool Language Scale-3 [PLS-3], advancing from 3 months behind their chronological ages to 1 month ahead. Regression and other analyses modeling child language development indicated that participation in Even Start could overcome the effects of low maternal education. These results indicate that Even Start is an extremely effective intervention, and will be expected to significantly increase children's readiness for school, prevent subsequent school failure, and increase parents' employability.

Talking about Feelings *Melissa M. Brown, Robert Curran*

Presenters: Melissa M. Brown, Robert Curran

The vast majority of the theories of mind research have been normative, delineating when children first become aware of their own and others' internal states. By age four, children typically demonstrate a subtle understanding of internal states. However, relatively little work has been done on the developmental implications of individual differences in children's awareness of and attention to internal state information. This study tests the hypothesis that children's tendency to attend to, think about, and talk about internal states will be predictive of their social competence with peers.

The subjects were 42 three- and four-year-old children attending a Head Start program in rural central Pennsylvania. Social competence was assessed via teacher ratings of social skills, sociometric reciprocated best friend nominations, amount of time children were observed in social play with peers, and the social agency and social closeness subscales of the Self-View Inventory, a measure of self-concept.

Children's tendency to attend to, think about, and talk about internal states was estimated by their use of internal state language while looking at a wordless picture book with their mothers. Home visitors videotaped mothers and children "making a story together" from Mercer and Marianne Mayer's wordless picture book *One Frog Too Many*. The videotapes were transcribed verbatim, and the number of times children mentioned a character's perceptions, feelings, cognitions, qualities of consciousness, dispositions, relationships, volitions, and inabilities was enumerated. A composite internal state language measure was tabulated by summing across all internal state categories. Due to their social natures, internal state categories of feelings, dispositions, and relationships between characters were also considered separately.

Individual differences in children's tendency to attend to and discuss fictional characters' internal states with their mothers predicted the peer-driven measures of social competence in reciprocated friendships and social play even when talkativeness was controlled for. On the other hand, the relationships between children's use of internal state language and teacher ratings of self-concept tended to dissipate when talkativeness was controlled for.

The next two questions then become: 1) how does attentiveness to internal states help children organize their social behavior; and 2) what is the origin of the individual differences in attentiveness to internal state cues? It is interesting to note that in the present data set maternal discussions and questions about characters' internal states were not particularly predictive of children's social competence, suggesting that socialization influences either do not occur in this context or occur at an earlier developmental stage.

Perceptions of Competence: Mediating the Effects of Low Income on Children's Reading Achievement *Julia T. O'Sullivan*

Presenter: Julia T. O'Sullivan

Children from low-income homes begin school at risk for underachievement in reading and fall farther behind as they get older. We need to identify the variables that predict reading achievement for these children in order to design effective prevention and intervention reading programs. Eccles proposed that 1) children's perceptions of their reading competence and their beliefs about the value of reading influence their reading achievement; and 2) children's beliefs about their reading are influenced by what their parents believe about the children's reading. That model was tested in this study with low-income families.

A total of 552 children (from grades three, six, and nine) and their parents, all from very low-income families, participated. The families lived in Newfoundland, Canada's poorest province. Most (75%) lived in rural areas and for most (80%) both parents lived in the home. Parents had an average of nine years of formal education, and most who worked outside the home were either fishermen/women or laborers in fish plants.

Children's reading achievement was measured by their performance on the comprehension subtest of the Gates-MacGinitie Reading Test and their school marks in reading. Two questionnaires were used to measure children's and parents' beliefs. Children's perceptions of their reading competence and their beliefs about the value of reading and the parents' beliefs about their child's reading competence and the value of reading for their child were also measured.

Performance on the Gates-MacGinitie Test indicated that, on average, the children were functioning at the bottom 25% of the population as a whole (scores for individual children ranged from the 1st to the 99th percentile rank). The children's school marks in reading were considerably better. For example, more than 60% of the children received a school mark of 76% or higher. Overall, children and their parents believed that the children were competent readers and that reading achievement was very valuable for them. At each grade, children's perceptions of their reading competence significantly influenced their performance on the Gates-MacGinitie Test, but their belief about the value of reading did not. Children's beliefs were influenced by their parents' beliefs, which were predicated on their child's school marks in reading. This model accounted for over 35% of the variance in reading achievement in grades three and six, but only for 15% in junior high.

By the third grade, these children were among Canada's worst readers, but neither the children nor their parents realized that they were underachieving in reading. One reason for this is that parent beliefs were influenced by their children's unrealistic school marks. The most proficient readers had the most positive reading beliefs, as did their parents, but it was beliefs about competence (what the child brings to reading), not about value (what reading brings to the child), that predicted reading competency. The findings suggest that programs designed to prevent or decrease reading problems in children from low-income families should focus on the family; encourage parents and children to believe in the children's competence as readers; and begin with preschoolers, as both beliefs and reading achievement are well established by the third grade.

Family Factors Associated with High and Low Reading and Mathematics Scores in Children from Low-Income Families *Frances A. Campbell*

Presenter: Frances A. Campbell

The purpose of the study was to learn how selected family factors might be differentially related to primary-grade achievement in reading and mathematics in children from low-income families. Measures of family demographics and kindergarten and first-grade academic scores were available for a sample of 167 children participating in a Head Start Transition Demonstration program. All children were from low-income families and 80% were African American. Slightly more than half were boys. Approximately two thirds lived in households without their father present. Most of the mothers were at least high school graduates, and 53.7 % of them were employed when the child was in first grade.

Children attended six different elementary schools. Three schools were randomly assigned to receive the Transition services; the other three were comparison sites. Parents were interviewed and completed questionnaires assessing the home environment in the fall and spring of the kindergarten year and also in the spring of the first-grade year. Children were administered reading and mathematics subtests from the Woodcock-Johnson Psycho-Educational Battery-Revised (WJR) in the fall and spring of kindergarten and in the spring of first grade. Analyses were designed to relate academic scores to child and family demographic factors. A secondary question was whether Transition treatment might buffer the child against family circumstances that would otherwise have a negative impact on learning.

Children in Transition and comparison schools gained approximately the same number of points from one year to the next on both reading and math tests. There were no gender differences in the percentage of boys and girls who scored low or high on either subject. Several of the family demographic variables distinguished children who scored higher from those scoring lower in reading, but few did for mathematics. For reading scores, high scorers had mothers with more education, were more likely to have employed mothers, were rated as healthier by their mothers, and their families had higher totals on the Home Screening Questionnaire (HSQ). In contrast, only the mean scores on the HSQ were significantly different for children scoring high and low on mathematics.

Scores from the total sample were used in stepwise regression analyses in which separate coefficients were calculated for reading and mathematics achievement. The outcomes for both subjects were WJR scores summed across kindergarten and first grade. Child characteristics, family structure, measures of the family environment and Transition treatment, plus Transition treatment x family variables were the predictors. The models accounted for approximately a quarter of the variance for reading ($R^2 = .24$) and for math ($R^2 = .23$). HSQ scores independently predicted math scores, and a similar trend ($p = .06$) was seen for reading. Transition treatment interacted with family size and showed a trend toward interacting with Home Screening Questionnaire scores ($p = .07$) to predict reading scores, and Treatment interacted with maternal education to predict mathematics scores. Rather than buffering the child against negative family factors, Transition treatment appeared to enhance family strengths in relation to children's academic outcomes.

Ready to Read: The Implementation (and Ongoing Evaluation) of a Parent-Child Reading Program for Head Start Families

David C. Diehl, Moncrieff Cochran

Presenters: David C. Diehl, Moncrieff Cochran

In response to the specific needs of local Head Start families, the Cornell Early Childhood Program (CECP), Tompkins County, New York Head Start, and the Tompkins-Seneca-Tioga branch of the New York Board of Cooperative Educational Services (BOCES) joined forces in a collaborative effort to develop a plan for maximizing the quality of parent involvement in local Head Start.

For the 1995-96 academic year, a participatory parent-child reading program for Head Start families was implemented and an evaluation was undertaken. The program was designed to foster the emerging reading skills of preschool children by directly involving their parents in the process. The evaluation plan for this project is based on multiple methodologies and measures within Jabobs's five-tiered approach to program planning and evaluation. This project was designed to expand the reach of parent involvement and to support positive reading practices in Head Start families.

Six Tompkins County, New York, Head Start sites were selected into the project based on considerations of their fitness as both program implementation and research sites. Sites were matched based on analyses of demographic similarity, and within each pair, one site was randomly assigned to program status while the other was assigned to comparison status. The sites selected included four rural sites and two urban sites in upstate New York. The rural sites were overwhelmingly White, while the urban sites were chosen because they provide greater diversity in racial and ethnic background. The participating families (about 50 program and 50 comparison families) represent a low-income population, with an over-representation of one-parent households.

The families in the three program sites participated in a parent-child reading and activity program. The program consisted of three primary components: 1) Book and Activity Packets: Each week a packet of parent-child materials were sent home with the child. These packets were made up of children's books and accompanying activities, which the families were able to keep. Each week, parents and children read the books together and constructed the corresponding activities. 2) Reading Support Visits: During the program, each family received approximately five home visits from a trained Reading Visitor. 3) Center-based activities: During the year, each site organized a variety of center-based activities, including Reading Program Kick-Offs and Family Reading Nights.

A variety of measures will be used to assess ongoing program progress, including parent attitudes and behaviors as measured by parent questionnaires before and after the program; ongoing formal parent feedback about the program; meeting notes and documentation of staff input; observational assessments of reading readiness in program and comparison-group children; and concept mapping techniques for program clarification and evaluation.

In a preliminary finding, we discovered that program staff rated parent effects as more important than any other type of effect, including effects for children. Given the traditional focus on children in early intervention programs, this finding may point to a nice balance between parent, child, and family effects in the current program and highlights the parent involvement orientation of this project and the staff involved.

The Relationship between Home Literacy and Parental Involvement: Validating Ratings of Parental Involvement in Head Start *Margaret Hiscott*

Presenter: Margaret Hiscott

Parental involvement in children's academic endeavors and school programs has long been considered an important determinant of the children's academic success, as seen in Bronfenbrenner's studies in the 1970s. Several recent studies have provided evidence relating parental involvement to children's academic success in elementary school, thereby lending credence to Bronfenbrenner's belief.

Many preschool programs for low-income families, such as the Head Start and Even Start programs, include parental involvement as a necessary component in the program and stress the importance of the parents' cooperation with the program. The programs expect parental participation in a general way, such as volunteering in the classroom, attending parent meetings, and participation in fund raisers. Few of the programs seem to expect parents to be involved directly in the education of their children. However, parental involvement, as measured through Head Start program director's ratings, has been shown to predict children's academic success.

This study examines the links between parental involvement, as measured by Head Start program directors, and home literacy. Directors rated the involvement of parents of 85 children attending Head Start centers on Long Island, NY. Home literacy was assessed through self-reporting of the parents on measures such as the number of books in the home, how often they read to their children, and how often they take their children to the library. Since these self-report measures are affected by social desirability, reading frequency was also measured through a recognition test of book titles the parents had been exposed to as part of an intervention program. In addition, parents reported on how much their children enjoyed reading activities at home. Multiple regressions found that a factor score of the home literacy measures and the book recognition test significantly predicted parental involvement. A factor of the children's interest in reading at home did not significantly predict parental involvement. Parental IQ was controlled for in the analyses.

The results of this study show that parental involvement as measured through Head Start directors' ratings is related to parental literacy activities at home. It is most likely that some third variable is causing the involved parents to also be the parents that are engaged in literacy activities with their children, such as reading picture books and going to the library. This third variable could be an underlying attitude such as parental interest in IQ, or it could be something more basic on a practical level such as parental free time.

It is interesting to note that the third variable driving parental involvement and home literacy activities is not child interest in reading or parental IQ. While both of these variables conceptually might seem to play a role in determining parental involvement, empirically they failed to significantly predict parental involvement in this sample of Head Start families.

Literacy and the Home Learning Environment

Language Enrichment and Phonological Awareness *Nell Carvell*

Presenter: Ann Minnis

We owe our children a future filled with promise, and for children in one low-income neighborhood in Dallas, Texas, the future looks more promising than ever. Through a partnership between a corporate foundation, a public school district, and two universities, in 1990, a model preschool was designed. This model preschool for 90 four year olds, the Margaret Cone Preschool, is a Head Start Center in an area marked by poverty, crime, and unemployment. Some of the services and activities at the Cone Center are common in Head Start Centers throughout the nation (e.g., parent involvement opportunities). Many of the components at the Cone Center, however, are at the vanguard and unique (e.g., the enriched language curriculum). The long-range goal is for the graduates of the Cone Center to complete high school and secure a job with the possibility of further educational achievement and future employment opportunities.

During the first two years of the model (1990-92), the children at the center received supplemental health, nutrition, and social services, and the teachers and staff provided extended hours each day, as well as a year-round program. In spite of these rich resources, the children continued to enter kindergarten performing well behind their chronological age according to the Battelle Developmental Inventory. At this point, the partnership had to make a critical decision: to discontinue, or to make significant changes in the program. They courageously chose to seek ways to strengthen the academic curriculum, as well as to continue the other supplemental resources to the center.

In 1993, the Texas Instruments Foundation approached the Learning Therapy Program at Southern Methodist University (SMU) with a request to develop a phonics-based, prereading program for the Center. After observing the children at the Center, the SMU team determined the greatest need to be in the area of language development. Over the next three years, the Language Enrichment Activities Program (LEAP) was developed.

This unique, multisensory, enriched language program provides activities to be used throughout the day for 20 weeks. It includes teacher training, model teaching by volunteers, parent workshops, and expandable lesson plans. The goal of LEAP is to prepare children to enter kindergarten functioning close to an age-appropriate level of development. LEAP emphasizes the areas of receptive and expressive language, phonological awareness, knowledge of the letters of the alphabet, basic concepts, and prewriting fine motor skills, thereby increasing the children's chances for success in kindergarten.

Pre- and postassessments document the gains made by the children who participate in the program. The 1995 Iowa Test of Basic Skills (ITBS) data from the neighborhood elementary school reveal the Cone children in cohort four performing an average of 15 percentile points above the children in the same kindergarten classes who did not attend the Cone Center. By entering kindergarten prepared to succeed, most of these children are completing the year performing above the national norm.

Family Characteristics That Contribute to Literacy Development in Former Head Start Children Attending Public School

J. Kelly McCoy, Gene H. Brody, Zolinda Stoneman

Presenters: J. Kelly McCoy, Zolinda Stoneman

During their initial transition into the public school system, children's likelihood of having a positive learning experience is based to a large degree on factors present in their homes. In particular, there are several characteristics of children's home environments that are likely to impact the gains they will experience in their literacy development. For the present study, caregivers' literacy skills, the literacy environment provided in the homes for children, families' incomes, the caregivers' level of psychological well-being, and the parenting style used in the home were all expected to contribute either directly to children's literacy development, or indirectly through their impact on the children's overall adjustment. In the three models tested, we examined the direct and indirect effects of the constructs identified above on 1) youths' literacy development as measured approximately one and one-half years later; 2) the change in their literacy scores from the time of their initial assessments in the fall of kindergarten to the spring of first grade; and 3) the youths' sense of importance about doing well and trying hard in the school activities, as measured approximately one and one-half years later.

One hundred fifty-five former Head Start children and their primary caregivers were initially assessed during the summer prior to, and the fall of, the children's kindergarten year as part of the National Head Start /Public School Transition Demonstration Project, and were again assessed in the spring of the children's first grade year. Fifty-five percent of the children were African American and 44% were White. Ninety-two percent of the primary caregivers were mothers, 4% were the children's grandmothers, and 1% were stepmothers.

We examined the implications of several family factors for children's emergent literacy using latent variable path analysis with partial least-squares estimation procedures, a structural equation modeling technique. In all three of the models, higher per-capita income was linked to higher levels of caregiver literacy and moderately linked to better caregiver psychological well-being, more open parenting style, and a more positive literacy environment for children. In all of the models, higher levels of caregiver literacy were linked to caregivers reporting better psychological well-being, a more open parenting style, and a more positive literacy environment for children.

Of central importance, we found that in the presence of the other predictor variables, caregivers' literacy influenced their children's vocabulary comprehension and their sense of importance about effort and performance in school indirectly through its effects on parenting style and the literacy environment provided to the children. In contrast, caregivers' literacy level, but not the literacy environment or parenting style, directly predicted a more general assessment of children's literacy development.

The models tested in this study indicate that certain aspects of children's literacy development appear to be better predicted by their caregivers' own literacy abilities and behavior, while other characteristics of children's literacy development and learning experiences are better predicted by the level of positive parenting and home literacy activities present in the home. Based on these findings, it would appear that an effective program for preparing children to have a positive learning experience, in general, as well as with specific regard to literacy development, must consider the significance of the family context. The degree to which parents are open and responsive to their children's opinions and ideas, and the extent to which they model literacy behavior, as well as provide a positive context in which children's literacy abilities can develop, are all important to children's educational process.

Literacy and the Home Learning Environment

Capturing the Richness of California's Even Start Projects *Anne E. Just, Sallie L. Wilson*

Presenters: Anne E. Just, Sallie L. Wilson

Even Start (ES) Family Literacy Program, a Title I-related, federally funded educational program administered by the states, integrates early childhood education, adult basic education, and parenting education for participating families with children zero to seven years old into a unified program to maximize family change and to improve learning opportunities for the children's future school success. Projects are funded for a four-year cycle, with the possibility of a second cycle. Funded projects have two evaluation requirements: 1) provision of data to the national ES evaluation; and 2) local evaluation of the project regarding its goals and objectives. The California Department of Education (CDE), as the state ES administrator, also needs to monitor and evaluate ongoing ES projects. To this end, the CDE and a select voluntary committee of ES project directors and local ES project evaluators developed and pilot-tested a statewide evaluation and assessment system between June 1993 and May 1995. The system uses a dual approach: project self-studies and CDE site validation visits. The purposes are to 1) link national, state, and local evaluation efforts together; 2) capture operational "richness" as a context for quantitative data; and 3) monitor the progress of ES projects.

The ES self-study document's six sections address basic elements of the overall ES program and of ES project operations: early childhood education, adult literacy/basic education, parenting education, parent-child interaction, agency collaboration, and project design/administration. Included are exemplary characteristics and success indicators based on best practices from pertinent research literature and from ES project directors and evaluators. The self-studies allow ES project personnel to determine how well their programs match these criteria and to identify areas for improvement.

The site visits validate project responses on the self-study, while enabling CDE staff to work with project personnel to enhance project quality. Four-member teams of state and local ES personnel use a semistructured interview protocol of 11 common questions during the two-day visits. The teams also use a 5-point project perception scale to summarize daily findings and to ensure within-team reliability.

The pilot test included two steps: 1) projects completing a self-study; and 2) a random sample of eight projects receiving a site validation visit. All projects operating more than one year completed a self-study and shared their responses and reactions to the document and the process with the CDE by May 15, 1995. Four first-cycle and four second-cycle projects were visited, representing 22% of ES projects operating more than one year, and representing geographic diversity and ethnic/racial variation. The pilot test lasted from November 1994 through May 1995.

Three types of findings resulted from the pilot test. Firstly, the composite perception scale ratings of the eight site-visited projects indicated the range of individual projects' understanding and implementation of the ES program. Secondly, high scores in the discrete categories of the project perception scale allowed the authors to discern distinguishing characteristics in these areas. Thirdly, the pilot test yielded information to modify the evaluation system.

All projects had a strong grasp of ES program essentials, given the limited range of the overall mean rating scores between 3.4 and 5.0, and a project's experience in ES was reflected in these same ratings, with second-cycle projects scoring between 3.7 and 5.0 versus first-cycle projects ranging from 3.4 to 4.3. However, the following differences appeared among projects and between the cycles: three of the four first-cycle projects had strong project leadership, sound

school district support, and solid collaborative arrangements; one fifth-year project garnered an overall mean rating of 5.0, and two sixth-year projects displayed weaknesses (no clear focus and staff instability) largely unanticipated in a second cycle.

The following distinguishing characteristics emerged: a clear project vision; pro-active director; ongoing evaluation conducted by evaluator actively involved with the project; staff development with follow-up; extensive networking and assigned responsibilities among relevant service providers; qualified staff working as a team; and continuous fiscal and project monitoring. The CDE and the voluntary committee analyzed project responses and suggestions from the pilot test. The self-study document received minor editing prior to use in the 1995-96 school year.

The pilot test indicated that the evaluation and assessment system met its intended purposes. Projects relied on both national and local evaluation data to complete their self-studies, and described their project strengths and improvement areas, thereby offering a context for quantitative data. Identifying the overall strength of the three first-cycle projects, and the "basic needs" of two second-cycle projects demonstrated the system's monitoring capability.

Book-Reading Styles in Families Headed by Poor, Teenage African-American Mothers: Implications for Research, Practice, and Policy *Pia Rebello, Terri Griffin*

Paper not available

The book-reading styles of 60 poor, teenage African-American mothers and their preschool children were examined. Findings suggest variability in maternal reading styles and the type of maternal-child talk occurring during the book-reading task. Results are discussed in terms of their implications for designing literacy intervention programs.

Stories from a First-Grade Writing Workshop: A Study in Constructing Narrative and Perspective *Suellen Butler*

Paper not available

Three composing strategies devised by children for drafting stories in a first-grade writing workshop were identified. Posted stories permit the audience to trace the transition in composing strategy from accounts of "things I know about" to affirmations of "things we know about" and finally to explorations of "things I want and we should find out about." Studying the stories and composing strategies of children in the writing workshop provides a context and method in which to examine the social construction of literacy.

Resilient Peer Training: A Preschool-Based Intervention to Improve the Social Effectiveness of Disadvantaged, High-Risk Children

Kathleen Coolahan, Patricia H. Manz, John Fantuzzo

Presenters: Kathleen Coolahan, Patricia H. Manz

Resilient Peer Training (RPT) is an intervention strategy for socially ineffective preschool children. The intervention pairs these children (Play Partners) with peers who are especially socially effective (Play Buddies) during classroom free play. This study extends the first evaluation study of the use of RPT in urban Head Start classrooms by refining the RPT strategy and conducting multisite randomized field tests of its efficacy.

RPT involves three components: 1) pairing a Play Buddy (PB) and a Play Partner (PP) for 20-minute play sessions; 2) establishing a Play Corner during classroom free play; and 3) training Head Start parent volunteers to serve as Play Supporters. Play Supporters set up the Play Corner and speak to the PB, concretely identifying past behaviors that have resulted in positive play interactions with the PP. After the session, the Play Supporter makes supportive comments to both children about their interactive play. The intervention involves, on average, 20 sessions over 8 weeks.

The effectiveness of RPT for improving the social functioning of isolated children was assessed through a post-only comparison of the peer interaction behavior of treatment and control children. Eighty-two socially ineffective Head Start children participated, 37 of whom had a history of maltreatment. Maltreated and nonmaltreated children were randomly assigned to RPT or control groups. Control children experienced the same number of play sessions as RPT children, but with randomly selected peers of "average" social ability rather than Play Buddies. Additionally, the Play Supporter only supervised their play and did not prompt and support the assigned classmate.

Outcome data were obtained from observations of interactive play during free play and from teacher ratings of social behavior (social skills, behavior problems, and interactive play) as assessed with the Social Skills Rating System (SSRS) and the Penn Interactive Peer Play Scale (PIPPS). The observational data were subjected to a series of group by maltreatment status ANOVAs to determine the intervention's effect on major developmental categories of play behavior (Collaborative, Associative, Social Attention, Solitary, Non-Play, and Negative Play). Children in the RPT group engaged in significantly more Collaborative play and significantly less Solitary play than did control children.

For the teacher ratings, overall effects were examined by a two-way MANOVA for sets of variables with group and maltreatment status as the two factors. For social skills, a significant main effect of group was found. Follow-up univariate ANOVAs showed significantly higher levels of the SSRS Self-Control and Interpersonal Skills variables for the treatment group. A main effect for group was also found for SSRS Behavior Problem scores. Subsequent univariate ANOVAs demonstrated significantly fewer behavior problems among treatment children. Finally, a significant main effect for group was obtained regarding teacher ratings of interactive play. Univariate analyses showed treatment children engaging in significantly less disconnected behavior and more interactive play behavior than control children. For each set of analyses, no significant abuse or abuse by group interaction effects emerged. These findings support RPT's effectiveness at increasing the interactive peer play skills of socially isolated maltreated and nonmaltreated Head Start children.

Working Together for Families: Pacific Lutheran University's Marriage and Family Therapy and Head Start Training Partnership Project

Teresa McDowell, Karrie Ferguson, Michelle Loiseau, Elizabeth Sullivan

Presenters: Teresa McDowell, Elizabeth Sullivan

Pacific Lutheran University's Marriage and Family Therapy (MFT) graduate program in Tacoma, Washington was awarded a grant to cross-train MFT trainees and Head Start staff, while providing services that would strengthen the healthy functioning of Head Start programs and families. Round One of the grant was awarded for the 1995-96 school year by the American Association for Marriage and Family Therapy (AAMFT) Research Foundation from funds donated by The Prudential Company. Round Two has been awarded for the 1996-97 school year.

The project explored how Head Start programs might use the services of family therapists, and how being involved with Head Start might enhance the training of MFTs. MFT trainees worked as systems consultants to both a rural and an urban Head Start program. Comparisons were made in working within each setting. MFT systems consultants provided a variety of services to the two Head Start programs, including staff/family consultations, family systems training, classroom observations, parent meeting facilitation, parent discussion groups, triage for families in crisis, and staff team-building.

The project developed a systemic classroom observation tool and process that standardizes and increases the productivity of the required observations. The tool reflects Head Start values and philosophy by involving and empowering staff, focusing on strengths and successes, and including parent input. Most importantly, it offers a format for both staff and the observer to view and intervene in the classroom as a system.

The project employed a solution-focused approach and followed a four-part consultation model that pertains to the organization itself, staff support and training, family support, and classroom involvement. The project was committed to the idea that when staff are well-trained, supported, and able to function healthily as a group, they can better serve and empower families.

The contributions made were not only to Head Start programs, but to the MFT field and trainees as well. MFTs, while experts in human systems, rarely apply their knowledge to large organizations or agency systems. This project allowed for the exploration of training beginning MFTs to apply what they know about family systems to Head Start and other large systems. It also offered beginning MFTs the opportunity to train and provide consultation to other professionals, and to offer direct services to young, low-income, diverse families.

Round two will continue this emphasis, expanding services to include more rural Head Start sites and an increase in direct services to families.

A Social-Emotional Intervention for At-Risk Four Year Olds

Susanne A. Denham, Rosemary Burton, Jennifer Mitchell-Copeland

Presenter: Susanne Denham

Reports of externalizing and internalizing behavior problems, which cause extreme difficulty for parents, teachers, children, and society as a whole repeatedly mention emotional factors. When developmental milestones of emotional competence are not negotiated successfully, preschoolers are at risk. Hence, a focus on emotional competence makes sense for effective early intervention. Nonetheless, few programs have explicitly focused on these goals. In the present investigation, such a multicomponent social-emotional intervention was tested. Children who experienced the intervention were expected to show significant positive change in their observed social/emotional behavior.

One hundred thirty children, 70 treatment and 60 control, were observed. They ranged in age from three and one-half to five years old. Seventy-six percent were members of ethnic minorities. Our first goal was for the teacher to develop a positive, consistent, supportive relationship with each child. This was promoted through the use of "floor time," a means of building a warmth and intimacy between caregiver and child. Second, thinking about the effect of one's actions upon others requires that the child understand the feelings of others. The link between feelings and their verbal labels was, then, the second component of the intervention. Once feelings are recognized and labeled, the child must learn to regulate the expression of those feelings into socially acceptable channels. Children were taught a method of controlling negative feelings called the Turtle Technique. The third component of the intervention was instruction in interpersonal cognitive problem-solving. Children were guided to develop the habit of generating multiple options, of evaluating these options, and of using the step-by-step means to reach their goal.

Pre- and posttest measures included the Preschool Competence Questionnaire (PCQ), which was completed by teachers. PCQ items tap positive peer interaction skills, conflict resolution behaviors, cooperativeness with peers and with adults, self-control capabilities, dominant mood, and emotional expressiveness. Second, an adaptation of the Minnesota Preschool Affect Checklist (MPAC) was used by independent observers at pre- and posttest, to summarize aspects of the expression and regulation of positive and negative affect, productive involvement in purposeful activity, impulse control and management of frustration, interaction with peers, and ability to respond prosocially to the needs of others. Three MPAC factors were isolated at both pretest and posttest: positive affect, negative affect, and productiveness. The peer skill scale was utilized separately.

Having the intervention, especially if one scored low on the PCQ at pretest, predicted PCQ posttest scores (and being a girl was a borderline factor in this prediction). For the positive affect factor, no one variable made a significant unique contribution to posttest scores. For the negative affect factor, having the intervention (independent of pretest scores), and being high on negative affect at pretest, predicted posttest scores. For both the productiveness and peer skill factors, having the intervention (independent of pretest scores, but especially if pretest scores were low) predicted posttest scores. In sum, children who were most in need of the intervention, as evidenced by low pretest scores, benefitted most regarding peer skill, productiveness, and overall teacher-rated social competence.

Age-Related Problem Behaviors in Young Children: What Rural Parents Want from a Visit to the Doctor *Holly A. Cloonan*

Presenter: Holly A. Cloonan

There have been relatively few studies of parental concerns among families with young children and no formalized study of the specific concerns of parents in rural areas. The purpose of the present study was to obtain data from rural parents on 1) frequencies of common problem child behaviors through the first three years; 2) child-rearing resources; 3) perceptions of pediatricians' and family practitioners' availability to serve as a resource; and 4) forms of help parents would like from their physicians.

A 25-item survey was mailed to 1,734 randomly selected rural and urban households of infants delivered at a university-affiliated medical center from 1990-93. Five hundred forty-five surveys were returned, yielding a response rate of 32%. Parents were asked about specific areas of concern (e.g., colic, sleep, temper tantrums), and about child-rearing resources, including their perceptions of the child's physician as a resource.

Over 80% of the rural ($n=396$) and urban ($n=149$) samples were married mothers. T-tests determined that the two samples significantly differed on age of parent, education, and income, such that the rural sample was younger, less educated, and had lower household incomes. Statistical comparisons utilizing frequencies and χ^2 analyses indicated behavioral concerns were age related. For example, problems with colic/fussing and sleep were more frequently reported in the younger age groups, and eating problems (31%) and negativism (61%) were reported more often by parents of children at or over two years. The majority of urban (88%) and rural (77%) respondents reported utilizing books and magazines as resources. Among respondents who had a pediatrician ($n=440$), 73% indicated they had turned to him or her for help.

On items reflecting parents' beliefs about getting information from their doctors, 88% of all respondents indicated they expected the doctor to provide information about behavioral concerns; however, nearly half (47%) agreed "the doctor talks to me only about my child's health or illness." A logistical regression procedure determined that rural and urban parents with lower incomes were significantly more likely to report that their child's doctor focused exclusively on health and illness ($p<.001$).

The majority of urban (84%) and rural (76%) parents reported they would like the doctor to "talk with me during well-child visits." Sixty percent of all respondents indicated they would like to receive written information on specific problem areas. Forty-four percent reported they would like to talk with someone else in the doctor's office such as a nurse or child specialist.

Consistent with the literature on anticipatory guidance, behavioral concerns of parents were age related. Remarkably, there were no appreciable differences between rural and urban parents in the frequency with which they identified their child's doctor as a resource for child-rearing information. The majority of all respondents expected information about problem behaviors from the physician, but half perceived him or her as focusing exclusively on health and illness, particularly parents in the lower income groups. Pediatricians and family practitioners serving families of all incomes are in a unique position to provide information on appropriate ways for parents to respond to behaviors prevalent in this age range.

Empirical Investigation of Efficacy in Home-Based Mental Health Care *Ann L. Athorp*

Presenter: Unable to attend

The study consisted of two experiments to examine the impact of home-based therapy on mental illness in multiproblem families. Review of the literature focused on the interplay of poverty and mental illness in defining multiproblem families and the utilization of home-based therapy with this population and others.

Experiment One focused on delineating the type and severity of psychological distress in families characterized as multiproblem. Subjects were 58 participants in the Community-Family Partnership, a Comprehensive Child Development Program located at Utah State University in Logan, UT. In this sample, serious psychological distress was evident, with depression in both men and women as a primary symptom. Female participants in Experiment One showed psychological distress across more subscales and higher standardized mean difference effect sizes on the global subscales of the SCL-90-R than male participants. Significant distress was also evident on the Somatization and Obsessive-Compulsive subscales for female participants and on the Hostility subscale for male participants. In a corollary to Experiment One, participants in this study also fit the multiproblem description based on their demographic characteristics.

Experiment Two implemented a home-based therapy program based on Sherman's Action Counseling model and evaluated its effectiveness in terms of reduction of psychological distress. Six individuals drawn from the Experiment One sample participated in Experiment Two. At pretest, they were not demographically different from the Experiment One sample and they exhibited severe psychological distress such that their score profiles on the Symptom Checklist 90-Revised met both of the case criteria for the instrument. These subjects participated in nine weekly sessions of home-based therapy based on the Action Counseling model. Therapy was very successful for one subject, moderately successful for four subjects, and not successful for one subject, using reduction of psychological distress as the measure of effectiveness. Additionally, Experiment Two examined elements of the therapy that contributed to effectiveness. The mastery and implementation of the 10 Action Counseling steps appeared to contribute to therapy success.

Family Foundations: The Implementation and Evaluation of a Head Start Violence-Prevention Program

Brenda Jones, Monique Better, Kimberly Kandziora, Ariana Shahinfar
Presenters: Brenda Jones, Monique Better, Kimberly Kandziora, Ariana Shahinfar

There is burgeoning evidence documenting children's exposure to community violence and its consequences, including traumatic stress symptoms, interpersonal difficulties, and aggressive behavioral problems. Research indicates that early onset of such behavioral problems is linked to later conduct disorder. Interventions have been mounted to assist children and families in coping with the effects of community violence. Early intervention efforts have been found to reduce later antisocial behavior in children.

Family Foundations is a pilot project designed to implement and evaluate a violence-prevention initiative with Head Start children. The goal of the project is to promote social competence in preschool children showing current aggression and at risk for later conduct problems. An important objective is to affect the social ecology of the preschool setting through the provision of school-based and family support services, including 1) home visits; 2) parent groups; 3) behavior management intervention; and 4) social skills intervention. Social workers and paraprofessionals provide the parenting intervention while teachers use behavioral management techniques and a social skills curriculum in consultation with project staff.

Of an initial sample of 156, forty-three children were identified to participate in the project due to elevated parental reports of externalizing behavior. Three classes were designated intervention ($n=19$) and three control ($n=18$). Initial assessment of the children and families included the following: the Violence Exposure Questionnaire-Preschool and Parent Versions; the Child Behavior Checklist; the Colorado Child Temperament Inventory; the Brief Symptom Inventory; the Family Environment Scale; and the Personal Resource Questionnaire.

The evaluation of the behavioral intervention included the Preschool Behavior Questionnaire, the Iowa Conners, and monthly behavioral observations by trained coders. The evaluation of the social problem-solving intervention included the What Happens Next Game and the Social Problem Solving Test-Revised. The parenting intervention was evaluated with the Home Observation and Measurement of the Environment and the repeat administration of screening measures. This study was conducted in two phases: 1) an initial assessment conducted in homes to identify participant children; and 2) the implementation and evaluation of the intervention, including a pretest, a six-month comprehensive intervention, and posttest.

Because the posttest assessment is currently under way, the intervention evaluation is not complete, but will be ready for presentation in April 1997. Preliminary data are as follows: Initial Screening: Prevalence of violence exposure: 66.2% of parents ($n=74$) and 77% of children ($n=74$) reported child exposure to some type of violent event. Relationship between violence exposure and behavior problems: Significant associations were found between parent report of child violence exposure and externalizing problems ($r=.26$; $p<.05$) and child report of violence victimization and externalizing behavioral problems ($r=.25$; $p<.05$). Comparison of children with and without violence exposure: Analyses of variance (ANOVAs) revealed that children victimized by violence had significantly more externalizing symptoms (ANOVA: $F(1,73)=5.90$, $p<.05$). Individual/Family Factors and Externalizing Behavior: Externalizing behavior problems in intervention and control children were positively associated with family conflict ($r=.29$; $p<.05$), parent psychological symptomatology ($r=.54$; $p<.01$), and child emotionality ($r=.42$; $p<.01$). Externalizing problems were negatively associated with maternal support ($r=-.26$; $p<.05$) and child anxiousness/fearfulness ($r=-.56$; $p<.01$). Behavioral Intervention Evaluation: There were no

significant differences between the intervention and control groups (repeated measures ANOVA: $F(1,33)=1.31, p<.26$) in observed behavior.

As has been found in other research on urban populations, children are exposed to elevated levels of violence. These findings also suggest a link between violence exposure and aggressive behavior. That specific aspects of child temperament (e.g., emotionality) were associated with externalizing problems suggests that some children may have some underlying vulnerability to aggressive behavior. The relationship between a child externalizing problems and decreased maternal social support and increased family conflict suggests that interventions should focus on the provision of social support and the facilitation of improved family relations. In regard to behavioral management, the lack of difference between intervention and control groups may be attributed to the failure of teachers to employ the recommended behavioral techniques on a consistent basis. The analysis of the other evaluation results should shed further light on which facets of the intervention were most helpful to children and families.

The Therapeutic Nursery: Evaluation of an Integrated Model for the Provision of Mental Health Services

Bruno J. Anthony, Robinson Munoz-Millan, Jennifer Branch, Taghi Modarressi, Duncan McCulloch, George Cohen, Dana Fay, Noreen Herbert

Paper not available

Foster Parents as Treatment Providers: The Role of Attachment in Foster Care Research and Intervention

Christine Tyrrell, Mary Dozier

Paper not available

Meeting Mental Health Needs in Head Start: Lessons from Research and Practice

Jane Kmitzer, Hiro Yoshikawa

Paper not available

A Model of the Relationships between Children's Cognitions, Interpersonal Negotiation Strategies, and Psychological Symptomatology: The Influence of Classroom Context

Joshua L. Brown, Stephanie M. Jones

Presenters: Joshua L. Brown, Stephanie M. Jones, Nina Chaudry

This study examines the influence of classroom context on the relationships between children's cognitions about aggression, aggressive behaviors, psychological symptomatology, and conduct problems. Data for these analyses come from a large-scale evaluation of the Resolving Conflict Creatively Program (RCCP), a comprehensive intervention in conflict resolution and intergroup understanding that has focused on 8,000-10,000 children and 500-600 teachers in 15 elementary schools, across four school districts in New York City. Data were collected from students via classroom-based questionnaires and teacher questionnaires at four different times across two years. These analyses focus on data from the first wave of data collection and only include data from eight of the schools (those in the highest and lowest intervention groups).

Classroom context was operationalized in two ways: 1) classroom disruptiveness and non-disruptiveness were defined based on the classroom observations and ratings of independent observers; and 2) a comparison of teachers' ratings of student's aggressiveness with levels of student self-reported aggression. Teacher reports of students' aggressive behavior were combined into a single scale, which was then regressed on all student measures to obtain an estimate of the discrepancy (the residual from this equation) between children's reports about their aggressive cognitions, behaviors, and psychological symptomatology and teachers' reports of their aggressive behavior. The residual score was then averaged within classrooms, and each student in a given classroom was then assigned the average residual score for that class. The sample was then split into thirds based on the frequency of these average residual scores. The top third (large positive residuals) represents students in classes where, on average, teachers overestimated student aggressive behavior in relation to student self-report. The bottom third (large negative residuals) represents students in classes where, on average, teachers underestimated student aggressive behavior, and the middle third (residuals close to zero) represents students in classes where, on average, teachers rated students similarly to the way students rated their own aggressive behavior.

Classroom Atmosphere Ratings: Results from regression analyses suggest that children's use of an aggressive strategy in social problem-solving situations is significantly positively related to an increase in self-reported conduct problems in nondisruptive classrooms but not in disruptive classrooms. Additionally, there was a significant positive relationship between level of depression and conduct problems in both disruptive and nondisruptive classrooms, but this relationship was significantly stronger for children in disruptive classrooms than in nondisruptive classrooms.

Teacher Bias: Children who report less hostile attributional biases are significantly more likely to use a competent strategy when responding to problem situations in classrooms where teachers have underestimated their students' aggressive behavior than in the accurate estimate or overestimate classrooms. Similarly, increased hostile attributional biases are related to increased levels of conduct problems significantly more in classrooms where teachers have underestimated student aggression. When teachers accurately rate student aggression, higher student anxiety is more significantly related to high student conduct problems than in classrooms where teachers overestimate student aggression. Conversely, in classrooms where teachers overestimate student aggression, higher levels of depression are more significantly related to higher conduct problems than in classrooms characterized by teacher accuracy. Taken together, these findings suggest that classroom context influences the relationship between children's interpersonal negotiation strategies and their levels of conduct problems in important ways.

Neighborhood Effects on Adolescent Outcomes: A Quantitative and Qualitative Analysis *Susan Clampet-Lundquist*

Presenter: Unable to attend

The concentration of poverty in urban neighborhoods and its potential effects on residents, particularly children and adolescents, has been a much debated research topic by scholars over the last decade. Researchers generally approach this topic using solely quantitative measures and draw conclusions on neighborhood effects and their method of transmission without any qualitative research to contextualize their quantitative findings. This research takes a quantitative and qualitative approach in assessing the structural effects of neighborhoods on the adolescent outcomes of noncompletion of high school and adolescent childbearing. I argue that this combination of methods has the potential to more accurately describe the complexity of neighborhood contexts, and thus can better inform urban policymakers.

In the quantitative phase of the research, I ran regression analyses on data for Philadelphia from the 1990 Census and from birth certificates from the Philadelphia Department of Public Health, using the block group as the unit of analysis. The results indicate that of the three structural variables (proportion professional/managerial residents, unemployment rate, and median household income), median household income is the most important in terms of explaining noncompletion of high school and adolescent childbearing. Additionally, median household income has a significant nonlinear relationship with noncompletion of high school. The structural variables did not explain adolescent childbearing as well as they explained the noncompletion of high school. One peripheral finding from the regression analyses was the non-significance of the proportion of female-headed households in a neighborhood in terms of teen childbearing, when other variables such as median household income are controlled for.

I interviewed adolescents for the qualitative phase of research, in order to ascertain their perceptions of structural factors at work in their neighborhoods, to gain a clearer idea of their norm networks, and to hear their attitudes on dropping out of high school and teen pregnancy. The transmission mechanisms described by the students appear to be far more complex than suggested by poverty researchers who rely exclusively on quantitative methods. In addition to the insight into transmission mechanisms, the qualitative data suggest implications about the opportunity structure of urban adolescents.

Perhaps the most important conclusion to draw from this research is that one cannot propose a simple theory of neighborhood effects relying on a single independent variable and a single mode of transmission. Everything—the structural variables, the history of the neighborhood, the modes of transmission, the context of the home environment—is interrelated, and to propose that one can understand neighborhood effects by not taking into account the complexity of the environment leads to a sterile and meaningless framework, and eventually erroneous and harmful policies. Future research should attempt to ethnographically analyze those neighborhoods whose median household income is below the poverty line. By understanding how structural variables shape young people's decisions and actions, more relevant urban policies can be formulated to address the needs of low-income adolescents and their families.

Contextual Assessment: A Qualitative Approach in Identifying, Understanding, and Developing Interventions for Children Who Are at Risk or Who Have Special Needs

Ken Marquard, Daryl B. Greenfield

Presenters: Ken Marquard, Daryl B. Greenfield

This study was part of a comprehensive evaluation at one site of the National Head Start/Public School Transition Demonstration Project. The Project's services were designed to provide a continuation through third grade of the educational, social, health, and parent involvement services typically associated with Head Start programs. Because the Transition Project was developed to improve outcomes for children who were at risk or who had special needs, our evaluation team was interested in an assessment process that could 1) identify these children at the earliest grade level; 2) understand the nature of their risk or special need; and 3) examine the relationship between understanding these conditions and the development of preventive intervention alternatives. For this study, we focused upon one kindergarten class comprised almost entirely of students from ethnic and language minorities. Participants included 29 of the students, the classroom teacher, her paraprofessional, most of the parents, and one of the researchers, who became a participant-observer in the classroom.

The theoretical orientation of this study was contextualist. This orientation examines interdependent relationships across contexts as these interact with the behavior, thoughts, and feelings of individuals, whether these contexts are of the here and now or removed in time and space. Besides "natural settings" such as a classroom, "context" can also refer to a continuous set of conditions such as parenting practices, or to specific situations such as a class lesson or activity. For such a complex study, we employed ethnographic methods and explored diverse contexts and leads from relevant data sources over time. The participant-observer visited this class weekly for half of the school year, conducted interviews with the other participants, and accessed testing and other records from Head Start and the public school.

The triangulation of data sources resulted in identifying over one half of the participating children (18) as at risk for poor educational outcomes/special needs. In analysis to understand the nature of risk/special needs associated with identified students, it was evident that the apparent severity of risk or special need was not necessarily related to an association with a "multiplicity of risk factors" often discussed in risk research literature. Most cases of risk or special need were idiosyncratic, and it was evident that actions or interventions would need to be tailored not only to provide direct intervention for individual students but also to address associated contexts. In the class studied, and in other classes studied in subsequent studies, typical school assessment practices rarely resulted in the use of any identifiable services, programs, or specific interventions for identified students. Although some students had been referred to the school's Child Study Team, no interventions were used even by the end of the school year. Only Transition Project services were beginning to address family contexts.

A qualitative contextual assessment approach based upon this study may offer schools an alternative to make a direct connection between assessment and intervention and provide the kind of early preventive intervention that reduces risk and addresses special needs more effectively.

A New Approach to the Assessment of Infants and Toddlers with Special Needs: A Videotesting Model

Rebecca R. Fewell, Michelle P. Glick, Salima Aliibhai

Presenter: Rebecca R. Fewell

Professionals involved in providing and evaluating services for infants and toddlers with special needs have begun to note disadvantages associated with the use of traditional, structured assessment instruments as measures of child development. These weaknesses may affect the performance of young children, especially those with disabilities. In addition, family members are excluded from the assessment process during the administration of standardized instruments. Therefore, the authors are developing a less-structured assessment model that includes caregivers as key participants in the assessment process. This "videotesting" model can be used by teachers, therapists, and researchers for screening, assessment, and program planning for young children. This presentation addressed the following three questions: 1) what is the relationship between videotesting model scores and structured testing scores; 2) are there differences between videotesting model scores and structured testing scores; and 3) do mothers of children who have more severe impairments interact differently than do mothers of children who have less severe impairments?

There are four main components of the videotesting model. First, the parent facilitates child engagement in gross motor activities on a classroom patio or playground. Next, during the play segment, the parent and child play with two different sets of toys. In the third segment, the child and parent share a book specifically designed for the videotesting. The parent has the child point to, name, or discuss the pictures on the pages. The last component of the videotesting model involves the administration of an informal screening test to the child. Both the parent and child are videotaped during all four portions of the videotesting. This study, part of a larger project investigating the development and use of the videotesting model, took place in a birth through two early intervention program in Miami, FL. The disabilities of the children who participated included neurological disorders, spina bifida, Down syndrome, genetic disorders other than Down syndrome, and developmental delays. The mean age of the children was 21.13 months.

Results revealed that all videotesting scores (cognition, fine motor, gross motor, receptive language, and expressive language) were highly and significantly correlated with structured testing scores. Videotesting cognitive and gross motor scores were significantly higher than structured testing scores, but videotesting fine motor scores were significantly lower than structured testing scores. There were no significant differences between videotesting and structured receptive and expressive language scores. Results also indicated that videotesting scores in the communication and motor domains were highly and significantly correlated with teachers' scores. There were no significant differences between videotesting scores in communication and motor development and teachers' scores. Lastly, mothers of children with more severe impairments were more directive than were mothers of children with less severe impairments.

Early results are encouraging and support the validity of a videotesting model. Future studies will continue to investigate and seek the most appropriate methods and measures to use in scoring and coding the videotapes.

Integrating Qualitative and Quantitative Analyses of Classroom Quality

Margaret Burchinal, Debra Skinner

Presenters: Margaret Burchinal, Debra Skinner

Qualitative and quantitative methods provide valuable tools for studying children's development. Combining the two methods provides multiple lenses on some phenomena, increasing the breadth and depth of findings and their validity. The most difficult aspects of combining methods are integrating data from both quantitative and qualitative sources and representing the findings in concepts and styles acceptable to both methodologists. The purpose of this poster was to demonstrate one way in which quantitative and qualitative methods can be integrated in analysis of data from the local Chapel Hill-Carrboro, NC Head Start Transition study.

Both qualitative and quantitative data collection and analysis methods have been employed in the local Head Start Transition study. The participants included 188 children in 50 kindergartens. Qualitative data were collected on a randomly selected subset of 21 children attending 14 kindergarten classes. The qualitative data included ethnographic observations of 14 kindergarten classrooms and 21 children, interviews with a focal group of the children, ethnographic interviews with teachers, and extensive fieldnotes on observations, spontaneous conversations, and interviews. Quantitative data collected on all children included measures of the quality of the kindergarten classroom, the family background, and child outcomes.

A qualitative analysis was conducted separately using analytic induction and negative case analysis based on detailed fieldnotes of classroom observations, conversations, and interviews. Ethnographers identified three dimensions that appeared to foster individual children's skills: 1) child-centered practice; 2) teacher sensitivity; and 3) classroom structure. Individual children seemed to blossom and excel in those situations where teachers gave more individualized instruction, teacher sensitivity was high, and classroom time and space were structured, but somewhat flexible and dependent on children's engagement in tasks.

The extent to which quality of the kindergarten classroom was associated with positive child development for all 188 children was examined in traditional quantitative analyses next. Regression analysis indicated that the four summary scores reflecting the child's language, reading, math, and social skills were not predicted from the ECERS total score, but were related to selected child and family characteristics in regression analyses.

The combined analysis involved incorporating into the qualitative analyses the three dimensions created by the ethnographer to represent quality within the observed classrooms. These dimensions were moderately to highly related to each other, and only modestly related to the quantitative summary score. This suggests they were describing aspects of the classroom not measured with our summary score. However, the regression analysis of the child outcomes measures for the 55 children who were in the classrooms observed by the ethnographers indicated that none of the quantitative or qualitative measures significantly predicted child outcomes.

In summary, we have demonstrated a "traditional" quantitative analysis, a qualitative analysis, and an integrated analysis of the same data, and we have contrasted the methods and interpretations. While quantitative analyses did not suggest that child outcomes were related to either the quantitative or qualitative measures of kindergarten, we believe that classroom quality plays a role in promoting academic skills of Head Start children. Failure to see effects in the quantitative analyses is likely due to collecting data in kindergarten, where teaching academic skills is not regarded as developmentally appropriate. In contrast, the qualitative analysis looked at individual variation through time and process, and suggested that certain individuals benefited in ways that the selected standardized scores did not measure.

The Family Start Project: Integrating Research, Assessment, and Service

Barbara Hanley, Marc J. Tassé

Presenters: Barbara Hanley, Marc J. Tassé

Family Start is a project that developed a research paradigm and service-model liaison model. It addressed the problem of lack of research programs that identify the characteristics of successful families that have children enrolled in Head Start programs and the lack of University-Affiliated Programs (UAP), Head Start partnerships that have developed joint projects for research and service. The following principal objectives were addressed: 1) to provide a mechanism whereby family assessment instruments can be applied to families of a local Head Start program; and 2) to establish a service liaison system between the Social Work unit of Ohio State University's Nisonger Center UAP and the social work/special services units of the Child Development Council, Inc. (CDC) Head Start program of Franklin County, Columbus, Ohio.

The participants of the Family Start project were recruited from CDC Head Start programs through presentations at parent orientations and center parent meetings, distribution of flyers, and phone calls during two and one-half years of the project. Overall, 271 families participated in the study of which 237 completed the whole procedure.

The family functioning assessments used five standardized assessment instruments: 1) Family Support Scale (FSS); 2) Family Needs Scale (FNS); 3) Self-Report Family Inventory (SFI); 4) Beavers Interaction Scales: I. Family Competence (BIS); and 5) Life Experiences Survey (LES).

Reliability and validity studies were carried out for each instrument used. Three of the five scales (FSS, FNS, and SFI) produced slightly different factor structures with the Family Start population than the original factor structure reported by the scales' authors. Overall, estimated reliability and validity for these scales were adequate.

The service liaison part of the model was developed primarily to deal with increasing or decreasing referrals, as needed. An adjustment to this program was made through the development of the Family Start Resources Room, which was a walk-in informational center. A Community Resource Manual was developed with and for the 15 Head Start programs involved in the project. This manual contained access information on the low cost/no cost social care services in their area.

This exploratory field design resulted in support for the concept that economically disadvantaged families are not dysfunctional families. Low-income families in this sample demonstrated strengths and characteristics not previously addressed in previous Head Start research. The Family Start project resulted in producing more appropriate factor structures for these family functioning scales used with this population, as well as providing preliminary norms for Head Start families.

Social Skills Rating System: An Empirical Analysis of Its Appropriateness for Head Start Evaluation

Patricia H. Manz, Virginia R. Hampton

Paper not available

The usefulness of the Social Skills Rating System for studying the effect of Head Start on preschool experience and kindergarten adjustment is evaluated. Results do not support the use of the preschool version in its present form. Further analyses are examining the preschool parent forms and the kindergarten versions.

The Harvard Outcomes Evaluation Database: Translating Data for Policymakers and Practitioners

Liza D. Cariaga-Lo, Pamela B. Miller, Heather B. Weiss

Presenter: Pamela B. Miller

The Harvard Family Research Project has been tracking family support and education programs for the last 10 years. One by-product of these efforts is the Harvard Outcomes Evaluation Database, a relational database serving as a mechanism for the collection, interpretation, and dissemination of family support program and evaluation data. Entries reflect a range of program designs and current evaluation practices. The database is relevant to practitioners because it serves as a repository of detailed information directly applicable to ongoing program practices.

The purpose of this poster was to illustrate the use of the database to summarize those key variables related to improved family and child functioning. The structure of the database allows us to ask questions about a range of important program and evaluation issues. Programming questions such as the following can be explored: 1) what types of services are provided; 2) who participates in these services; and 3) what types of programs are more likely to retain program participants? Evaluation questions such as "How are program outcomes measured" and "What type of service mix is related to positive outcomes" can also be addressed.

Our current data indicate that most of the family support programs included in the database provide both home-visiting and structured parent education activities. The majority of program participants are low income and come from single-parent households. Drop-out rates are extremely varied, and appear to be associated with program duration.

Program outcomes are measured by a wide variety of both standardized and "home-grown" measures. Outcomes measured by standardized instruments are more likely to show more positive differences between those who received program services and those who did not. Level of service comprehensiveness is related to significant program effects for both parent and child. Key elements associated with these effects include service mix, intensity, and targeting both the child and parent together.

There is a need for good theory and assessment to provide consensus regarding the most effective conditions and practices that promote optimal outcomes. Using Bronfenbrenner's ecological model, we have begun to consider the variables relevant to effective program design. By mapping participant characteristics, program factors, and outcome variables, we can visually display the interrelationships across different domain levels.

What is the utility of such conceptual maps? Ecological maps move beyond simple description towards a more dynamic multifaceted summary of program data. They afford program practitioners, policymakers, and researchers a "snapshot view" of what factors and which ecological domains are being accounted for or overlooked in their program implementation. Thus, we can simultaneously examine the advantages and limitations of a program.

By using the evaluation database to summarize multiple program findings, we can provide additional evidence for the effectiveness of multiservice family support programs. Prior attempts at data mapping have not adequately accounted for dynamic and increasingly complex programmatic models, such as recent Head Start program innovations. The Harvard Outcomes Evaluation Database captures program elements that can be tailored to the needs of multiple stakeholders seeking current and comprehensive data.

New Approaches, Methods, and Measures

A Tool for Individualized Curriculum Planning: A Developmentally Appropriate Child Assessment for Head Start *Steffen Saifer*

Presenter: Steffen Saifer

An early childhood assessment tool was developed by the researcher and colleagues from Head Start programs in Oregon for the purposes of individualized curriculum planning and tracking children's progress and assessing children's social competence. It was developed in response to a need for an observational, contextual, child assessment instrument that would focus extensively on social and emotional development, help guide teachers towards best curriculum practices, and meet common criteria for effective, appropriate, and equitable assessment. Theoretical constructs of interactionalism, multiple intelligences, dispositions, and developmentally appropriate practices were used to inform the construction of the tool. In addition, the researcher attempted to develop a tool that would be effective for use as a Head Start program evaluation research instrument, accurately measuring the construct of social competence.

A multifaceted research design was developed to determine curricula, item, construct, and congruent validity; test-retest, interobserver, and internal reliability; and various measures of utility for the assessment tool, The Oregon Assessment. Research methods involved a representative random sample of 200 children in four early childhood programs in two northwest states and the use of two different surveys, one completed by 15 early childhood experts and one by 114 users of the assessment.

The Oregon Assessment was found to be an instrument with an acceptable degree of item, curricula, and construct validity; a high level of test-retest, interrater, and internal reliability (coefficient alpha = .879); and an acceptable degree of utility. Only 1 item of 60 was found to have low item validity, and three other items were rated lower than others (although generally positive) on both item and curricular validity. Reliability and validity were strongest for the self-concept domain, a construct usually considered to be nebulous and difficult to accurately measure. It was found to have significant but moderate congruent validity with total scores on The McCarthy Scales for Children and on The Vineland Adaptive Behavior Scales. Users throughout the U.S. found it generally useful; nearly 87% of respondents agreed or strongly agreed that the results accurately reflect the skills, behaviors, and abilities of their children. They indicated that it takes about one hour to one and three-fourths hours to administer over a period of about two weeks. The length of time it takes to administer emerged as a concern from users.

Recommendations were made to refine the instrument and user manual and to develop a shorter version. It was found to have great potential use for promoting best practices in early childhood programs and for use as a research instrument for program evaluation, particularly for Head Start, as it can effectively measure the construct of social competence.

Parents as Teachers: Workshops Using Mediated Learning Experience Approach

Nellie Zambrana-Ortiz

Paper not available

Spanish translation and back translation were conducted on the Mediated Learning Experience Scale. A Pilot Study helped to manage the scale and its components. Agreement analyses were conducted among professionals who were trained to assess four pairs of parents and their children. Intervention workshops with the participants will be conducted.

Identifying the Social Supports for Peer Competence in Children Attending Head Start: A Structural Equation Analysis

Brian E. Vaughn, Kelly K. Bost, Wanda N. Washington, Kerry L. Cielinski, Marilyn Bradbard

Presenter: Brian E. Vaughn

Most research on the peer relations of preschool children is centered around the "social competence" construct. In many studies, the construct is circumscribed in terms of a few "social skills" or competencies used to achieve social goals. Problems arise when the skills defining social competence change as a function of cultural milieu, developmental level, or specific social contexts. Waters and Sroufe proposed a broader definition of social competence as the effective management of behavior, affect, and cognition within social contexts that affords the child the possibility of achieving social goals, without constraining the opportunities of peers to achieve their own social goals and without constraining the child's options for attaining future social goals. This definition permits the repertoire of social behavior falling within the domain of social competence to change as a function of varying contexts. However, measurement requires assessments that are both broad-band and contextually labile. Bost and Vaughn suggest that young children receive support for competence with peers from relationships developed in the family and in the wider social network beyond the family.

The goals of this Head Start/University Partnership project were to describe differences regarding social competence for children attending Head Start and to examine supports available from the larger social network and from the concurrent relationship of the child with her or his primary caregiver. We hypothesized that children whose social support networks and family relationships were characterized as more supportive would be more socially competent with peers. Data for approximately 200 African-American children attending Head Start were available to evaluate the hypotheses.

Assessments included direct observations of behavior summarized using Q-techniques, observations of visual regard received from peers, and sociometric interviews. Social network information was obtained using a modified Zelkowitz interview. Measures of embeddedness (network size), support received, and perceived support were obtained. Assessments of the child-caregiver relationship were obtained using the Attachment Q-set (AQS).

Analyses considered first relations of variables within content domains to determine whether the social network and social competence constructs could be fairly characterized as multifaceted, higher order constructs. Models treating both of these constructs as unified, but multidimensional fit the data in structural equation analyses. The final model considered pathways from parent-child relationships to the social network and to social competence and a pathway from the social network to social competence. This model fit the data with a high degree of confidence.

The data indicate that both family relationships and social network support contribute to children's social competence. Furthermore, the quality of the parent-child relationship appears to be a determinant of the support available from network members. Children more secure and confident in their relationship with their mothers report larger and more supportive networks of social relationships. These findings indicate that social competence is measurable for children in Head Start classrooms and that individual differences are related to variability in other relevant domains. The data further indicate that very young children can provide valid information concerning their social experiences. Finally, the data help illuminate the nature of supportive relationships for low-income African-American children attending Head Start.

Children's Understanding of the Structure of Activities in Child Care Settings

Nancy W. Wiltz, Elisa L. Klein

Presenters: Nancy W. Wiltz, Elisa L. Klein

This study explores young children's perceptions about the structure of daily events and their preferences for particular types of activities that occur at child care. Previous research has consisted of observations of children at school. This research asks young children themselves about the structure of classroom events and their preferences for particular types of school activities in order to gain insight into the children's thinking and to determine if children's ideas about school and curriculum are congruent with teachers' rationale for offering these activities within a child care setting.

Subjects were 50 three to six year olds from a multiethnic, traditional, private nonprofit child care center in a suburban metropolitan area. Children were interviewed over a two-year period. The first cohort consisted of 25 children (14 boys, 11 girls, mean age = 53 months) who were interviewed using a protocol adapted from previous research about life in school. In order to look at possible changes in children's perspectives over time, a second cohort of 25 children (12 boys, 13 girls, mean age = 61 months) was interviewed using the same protocol and informal group interviews. The purpose of the interviews was to access children's understandings about various aspects of their life in child care, including their preferences for and purposes of certain curricular activities (i.e., circle time).

Using Spradley's qualitative domain analysis, activities were categorized as either structured or unstructured. Structured activities were teacher controlled, and were related to traditional academic areas (curriculum), routine tasks (function) or construction activities (construction). Identification of structured activities as salient school events increased with age, ranging from 55.5% for the three year olds to 90% for six year olds. Age differences between preferences for activities were significant ($\chi^2 = 8.68$, $df = 3$, $p < .05$) and were especially noted in the curriculum category.

Unstructured activities included pretend and dramatic events (creative play) or play with objects (play with toys). Children's identification of unstructured activities steadily declined with age. While a total of 45.5% of the three year olds showed a strong preference for unstructured activities like play, only 10% of the six year olds did. Within the two subcategories, a precipitous change was seen after age four. Although the decline in play activities was moderate between the ages of three and five, there was a dramatic decrease as children entered formal school. Distinctions between work and play became increasingly distinct with age. Younger children identified play as the primary activity of school while older children cited work as the primary activity ($\chi^2 = 11.93$, $df = 1$, $p < .001$).

This study supports the contention that children as young as three have knowledge of prominent activities at child care. Delineation of structured activities increases with age, while identification of unstructured, play-related events decreases markedly as children get older and are enculturated into school-like environments.

Friendship Quality, Sociometric Status, and Loneliness in Abused and Nonabused Children

Tasha R. Howe, Mary Flyr, Mara Welsh, Ross D. Parke

Presenters: Tasha R. Howe, Mary Flyr, Mara Welsh, Ross D. Parke

The goals of the study were to compare the social adjustment of abused and nonabused children and to examine whether sociometric status and friendship quality differentially predict children's loneliness and teacher ratings of peer behavior. Thirty-five abused children from a structured residential treatment center and 43 nonabused children from the elementary school in which the abused children were enrolled were compared on sociometric status, loneliness, teacher rated behavior, and two measures of friendship quality (observational and self-report). All children were assessed on loneliness. The children with friends (based on reciprocal nominations during sociometric assessments) were assessed on friendship quality during free play and game play and were administered the Parker and Asher Friendship Quality Questionnaire.

Results revealed that abused children were not rated lower sociometrically than nonabused children. Abused children did not differ from control children on several measures of friendship quality, such as resolving conflicts and helping each other. However, abused children were observed to be more negative and less proactive in their interactions. They also rated their friendships as being more conflictual, and as higher on betrayal and lower on caring. Friendless abused children scored highest on loneliness; control children with friends scored lowest. Several of the friendship variables accounted for significant variance in teacher ratings and loneliness, above and beyond that accounted for by sociometric status.

The results challenge the common assumption that abused children's relationships are always more maladaptive than nonabused children's. The pattern of difficulties that were exhibited by abused children (conflict, betrayal) provide a focus for peer-based interventions in treatment centers and schools.

This study contributes to the scant literature on abused children's friendships and illustrates the importance of a multimethod assessment of social adjustment for abused and nonabused children.

The Influence of Physical Environment on Children's Play

Teresa Acosta, Deborah Edward

Paper not available

The sociodramatic play behaviors and verbalizations of 16-20 low- and middle-SES children in familiar versus novel play settings in both the classroom and in a children's museum were compared and analyzed in this qualitative study. The question of how the familiarity of the play setting influences the sociodramatic play of low- and middle-SES preschoolers was explored.

Assessing Head Start Children's Interactive Play: Penn Interactive Peer Play Scale

Virginia R. Hampton, Julia L. Mendez, John W. Fantuzzo

Presenters: Virginia R. Hampton, Julia L. Mendez

Play is a primary context in which preschool children acquire the social knowledge and interactive skills with peers that are necessary for social development. Unfortunately, an increasing number of children are living in poverty, which can adversely affect the acquisition of social competencies. Head Start and other early intervention programs seek to enhance the social development of low-income, preschool children. This goal must be informed by research indicating the most effective practices for low-income children. Such research depends on the availability of developmentally appropriate and culturally sensitive assessment instruments to guide the planning and implementation of early childhood intervention. However, few psychometrically sound and developmentally appropriate behavior rating scales are available for preschool children.

In response to this need, the Penn Interactive Peer Play Scale (PIPPS) was developed. The PIPPS is a teacher rating instrument for identifying interactive play behaviors of ethnically diverse Head Start children. The instrument differentiates children who successfully establish and maintain positive peer play relationships from those who are less successful with peers. The PIPPS was developed collaboratively with university researchers and Head Start teachers and parents. Identification of the most frequent and salient behaviors that reliably distinguished the "high" players from the "low" players were made during observations of children's play. These behaviors were crafted into 36 Likert-format scale items. Teachers indicated the frequency with which they had observed each behavior during play activities within the past two months. Piloting of the original scale led to minor revisions, resulting in the final 30-item measure.

An evaluation of the validity of the modified PIPPS was conducted with an ethnically diverse sample of 1,186 urban Head Start children. To assess the construct validity of the PIPPS, a series of common factor analyses was conducted. Three factors were obtained: 1) The Play Interaction factor represents children's play strengths, and includes behavior such as being helpful, comforting other children, and demonstrating creativity in play; 2) The Play Disconnection factor describes children's withdrawn behaviors, such as being ignored by other children and hovering outside the play group; and 3) The Play Disruption factor relates to aggressive, antisocial play behavior, such as starting fights and arguments. Concurrent validity was established through play observations, sociometrics, and teacher reports of children's social competence, learning behavior, and problem behavior using the Social Skills Rating System, Preschool Learning Behaviors Scale, and Conners' Rating Scales.

The validation of the PIPPS indicates its usefulness in identifying the interactive play behavior of urban, ethnically diverse Head Start children, and for identifying candidates for intervention. The PIPPS also provides information about children's strengths and resilience in high-risk environments. These findings represent a promising response to mandates to develop culturally and developmentally appropriate assessment methods for the growing population of ethnically diverse children.

Contingent Self-Worth: Relation to Judgments and Implicit Theories in Young Children*Melissa L. Kamins, Claudia M. Mueller, Carol S. Dweck**Presenter: Melissa L. Kamins*

Children's sense of contingent self-worth and their postfailure self-judgments were examined. The concept of contingent self-worth refers to individuals' tendency to view their personal worth as being determined by, and therefore contingent on, characteristics and outcomes. In this study, we looked at how kindergartners' views about the love they receive from their parents affects their self-judgments and their expectations of parental support. Our hypothesis was that kindergartners who view their worth as contingent on their performance and behavior would be more likely to react negatively to setbacks than children expecting noncontingent regard. Specifically, we predicted that the group of "contingent" children would be more likely to judge themselves harshly after failure and to report more negative affect than children in the noncontingent group. Also, we predicted that these children would be more likely than the group of noncontingent children to view mistakes as indicating "badness" and to believe that "badness" is a trait that is stable over time. We explored how children's expectations of support from their mothers might differ for the two groups. Children who endorsed the contingent view were shown to be more vulnerable in the following ways: they showed more negative self-judgments, showed greater drop in affect, and expected less support from parents after encountering a setback.

Children's beliefs about contingent regard were measured using the following question: "Some kids believe that they deserve love from their parents all the time, no matter what, and some kids think they deserve love only when they are good. What do you think?"

Forty-three kindergartners were divided into a contingent-regard group and a noncontingent group based on their response to this question. We measured prefailure affect, and then acted out with the children three scenarios in which the child worked on a task in school but failed to complete it correctly. We gave participants the following dependent measures: Post-failure affect measures; Self-rating measures; Implicit theory measures; and Role-play of mother on telephone.

The contingent-regard group rated themselves significantly more negatively than children in the noncontingent group after failure ($p=.01$). The contingent group of children also showed a significantly larger drop in affect from prefailure to postfailure than the noncontingent group ($p=.04$). In addition, children in the contingent group were significantly more likely to view mistakes as indicating "badness" and to believe that "badness" is stable over time ($p=.001$). In role-play, the contingent group showed that they expected less praise, less consolation, and less constructive support from their mothers after failure than the noncontingent group ($p=.06$).

The results support our hypotheses. The measure of contingent regard was demonstrated to be a predictor of children's postfailure self-judgments, affect and expectations from parents. We believe this finding has important implications for examining children's coping behavior. The conception of contingent self-worth can contribute to our efforts to understand why some children develop effective coping strategies and others are vulnerable to helpless behavior.

Building Young Children's Hierarchic Understanding: A Proposed Form of Intervention *Leslie K. Grier*

Presenter: Leslie K. Grier

There has been a growing interest in young children's conceptual development. Mervis and Crisafi indicate that young children more readily understand categories at the basic level, where there is great similarity within groupings and marked differentiation between groupings, as opposed to the broader and subtle distinctions at the superordinate level. Furthermore, superordinate relations are understood better than subordinate relations. Lucariello, Kyratzis, and Nelson suggest young children's hierarchic understanding is dominated by slot-filler categories where superordinate relations are represented by thematic or "spatiotemporal" markers (e.g., school versus play clothes). With age, taxonomic organization becomes less complementary and more conventional. Lucariello, Kyratzis, and Nelson further suggest that slot-filler category relations provide the foundation for conventional groupings.

The issue addressed here is what kinds of instructional techniques can be employed to advance young children's hierarchic understanding. Conventional understanding develops with age and will be required. However, the extent to which individual children adapt is variable and depends on several factors. Thus, prior exposure to and encouragement of more advanced ways of organizing and perceiving information may be beneficial.

A method for facilitating young children's hierarchic understanding is proposed that incorporates Constructivist methods and an Active-Interrogative elaborative strategy. Constructivist methods presume learning to be self-guided and situated in prior knowledge. Thus teachers are cofacilitators of learning. Teaching models that assist students in building knowledge from existing schemata are consistent with this perspective as the four-phase teaching model by Eggen and Kauchak.

The Active-Interrogative elaborative strategy, which prompts individuals to generate causal associations between items, is an effective strategy for young children aged four and five. This is linked to the fact that it 1) prompts a thorough analysis of the items; 2) promotes precision in understanding; and 3) requires self-generation. Self-generated connections are consistent with the knowledge base that supports learning. Thus, the Active-Interrogative strategy could be intertwined with the four-phase teaching model to broaden children's hierarchic understanding.

First, the teaching model would be employed to familiarize children with basic-level groupings from a designated superordinate category (e.g., cats and cougars...from category Feline). Afterwards, the Active-Interrogative technique would be used to facilitate hierarchic understanding. The Active-Interrogative strategy is less needed to familiarize children with basic-level categories. It is most beneficial to younger children when the relation between items is less explicit. The instructional time frame can vary from several days to weeks.

By integrating a constructivist and information-processing orientation in analyzing concepts, young children may begin to think about them in broader ways. Using children's own schemata and experiences as the basis for analysis may also prompt further inquisitive behaviors where items are perceived and grouped in a more flexible and broader manner.

Friendships among Children Who Attend School-Age Care Programs *Ellen V. Jacobs*

Presenter: Ellen V. Jacobs

The current friendship literature indicates that children need to have at least one good friend for healthy social development. Children who are without friends or who are rejected by their peers are at risk of developing long-term problems such as delinquency, neuroses and psychoses. Therefore, it is important to examine children's opportunities to develop friendships with peers. Children require time and opportunity to form friendships. Kindergarten children who attend school-age programs at the end of their kindergarten day may have an advantage in terms of friendship formation because they are with a set of peers for an extended period of time each day and have more opportunity to develop friendships. However, they may be at a disadvantage because peers with whom they interact after school may not be those they would choose to be with, and their formation of friendships may be impeded.

To explore this issue, the "best friendships" of 213 kindergarten children, 86 who attended school-age care programs (SAC) and 127 children who returned home to their parents at the end of the kindergarten day (HC), were studied. Mean age of the children was 71.1 months. Demographic information and day care history were obtained from a telephone interview with parents. Socioeconomic status was determined (Hollingshead Four-Factor Index of Social Status). Peer ratings and peer nominations of first, second, and third "best friends" were obtained. An adaptation of the Friendship Quality Questionnaire (FQQ) was administered. The School-Age Environment Rating Scale measured the quality of SAC programs children attended.

There were no differences between peer ratings assigned to HC children by either SAC or HC children. There were no differences between the ratings assigned to SAC children by HC or SAC children. Thus, likeability ratings were not related to care status. Frequency with which HC and SAC children were nominated by their peers as first, second, and/or third best friends was not significantly different. However, significant differences between groups was evident when "best friend" nominations were examined in terms of the after-school status of the nominator and nominee. Thirty-seven percent of SAC children received one to four nominations as a "first best friend" from other SAC children; 15% of HC children received one to four nominations as a "first best friend" from SAC children. Forty-one percent of HC children received one to five nominations as a "first best friend" from other HC children; 21% of SAC children received one to four nominations as a "first best friend" from HC children. On the FQQ, SAC children had a more conflict-laden "best friend" relationship than HC children.

This study indicates that children tend to select best friends from those who have similar experiences and that there are no differences in the likeability ratings of SAC or HC children of kindergarten age. Although friendship choices among SAC children may be constrained by their after school care, they have friends and their friendships look like relationships that afford them the opportunity to argue, negotiate, and compromise.

Managing Social Relationships and Daily Routines: Preschoolers' Physiological Reactions to Normative Stressors

Kathryn Tout, Michelle de Haan, Jordan Hart, Megan Gunnar

Presenter: Kathryn Tout

Children attending child care centers and preschool programs face daily challenges: they must adapt to routines and interact appropriately with other children and adults. One way the body reacts to challenge or stress is by producing hormones. Cortisol is one of these stress hormones. It is produced by the hypothalamic-pituitary-adrenocortical (HPA) axis, a stress-sensitive physiological system that mobilizes energy resources, suppresses activity of the immune system, and influences learning and memory. Negative emotion and a lack of perceived control over stressors are conditions that are associated with increased activity of the HPA axis (i.e., higher cortisol production). The goal of our research program is to understand individual differences in the way preschoolers respond, both behaviorally and physiologically, to normal challenges in their environment. We examine these responses by observing classroom behavior, obtaining ratings of children's typical behavioral styles, and by collecting daily samples of saliva (which are later assayed for cortisol).

Our poster presentation provided a concise overview of studies we conducted in four early childhood settings: a laboratory preschool, a university-based child care center, and two community child care centers. The children ($N=151$, ages ranging from 2.75 to 5.5 years) who participated in these studies represent a racially and socioeconomically diverse sample. We focused on the following questions: 1) how can we characterize preschoolers' patterns of daily cortisol production; 2) are salient behaviors, specifically aggression/anger and shyness/withdrawal, related to patterns of cortisol production; 3) is preschoolers' social competence related to patterns of cortisol production; and 4) are the findings generalizable across different early childhood settings?

In our results, we noted considerable variability in children's patterns of daily cortisol production. Children's average cortisol values were comparable across the four settings, but clear individual differences emerged. While some children's values were relatively stable over the collection period, other children's values varied dramatically across days. We indexed this variability (i.e., cortisol reactivity) by subtracting the 50th percentile in children's distribution of cortisol values from the 75th percentile. Thus, children with more stable values had low cortisol reactivity scores while children with more variable daily values had high cortisol reactivity scores. We then examined the correlations between cortisol reactivity, aggression/anger, shyness/withdrawal, and social competence. No consistent patterns were found across settings for aggression/anger or shyness/withdrawal. Social competence, however, was consistently negatively correlated with cortisol reactivity (average correlation across settings was -0.57).

The finding that social competence is related to lower cortisol reactivity highlights the importance of fostering children's social competence in early childhood programs. Because frequent and sustained elevations of cortisol suppress activity of the immune system, it may be that socially competent children experience less illness. Thus, programs that promote social competence may not only enhance children's behavioral functioning, they may also support healthy physical functioning.

The "D.C. Study": A Longitudinal Look at Children's Development and Achievement under Varying Educational and Familial Conditions *Rebecca A. Marcon*

Presenter: Rebecca A. Marcon

This longitudinal study began in the 1986-87 SY (with four year olds enrolled in Head Start or public prekindergarten) in response to an unacceptably high first grade retention rate, despite heavy investment in early childhood programs by the District of Columbia Public Schools. Because it could no longer be assumed that just any preschool curriculum would achieve positive results, the "D.C. Study" sought a more effective match between curriculum and child characteristics by clarifying the differential impact of preschool models on long-term school success and development of inner-city children. The impact of parent involvement and early risk factors were also examined.

The "D.C. Study" initially included three cohorts of four year olds (Classes of 2000, 2001, 2002) enrolled in one of three different preschool models (PK) identified for this study (child-initiated, academically-directed, and middle-of-the-road) prior to entering kindergarten. Upon entering kindergarten, PK children were matched with same-sex classmates who had not attended Head Start/Pre-K (K-only). Replication of initial findings in all three cohorts led to a decision to continue follow-up studies with just the Classes of 2000 and 2001.

Recently reported follow-up data included 461 children (70% recovery rate) enrolled in 95 different public schools in Washington, D.C. This sample was 97% African American and 54% female, with most children (76%) qualifying for subsidized lunch based upon low family income, and 72% living in single-parent homes. Wherever possible, data were analyzed using a covariate (eligibility for subsidized school lunch) to control for possible economic differences between children.

Attending either Head Start or prekindergarten prior to entering kindergarten had a positive impact on inner-city children's development and achievement in both the short- and longer term (effect sizes were moderate). The type of preschool intervention was especially important, with the negative impact of didactic, academically directed preschool becoming most evident in the transition from third to fourth grade. By fourth grade, these children had fallen behind their peers in all academic areas except handwriting. They were also notably lower in social development and adaptive behavior, and exhibited a higher incidence of maladaptive behavior. Pushing children too soon into "formalized academics" can backfire when children move into the later childhood grades, where they are expected to think more independently. In contrast, long-term positive affects of active, child-initiated early learning experiences were clearly evident in the transition to the later childhood grades. Failure to fulfill even the most minimal expression of parent involvement represented a clear danger to children's future school success (i.e., increased placement in special education, increased retention in grade). The need to concentrate spending on intense early intervention was identified. In particular, receptive language deficits in kindergarten were linked to higher incidence of maladaptive behavior in fourth and fifth grade. Immediate attention must be focused on children who are at increased risk of developing academic, developmental, and/or behavioral deficits. This study's findings provide the basis for ongoing systemic change in the public schools of Washington, D.C.

Parenting among Low-Income African-American Single Mothers with Preschoolers: Patterns, Predictors, and Child Development

Sharon M. McGroder

Presenter: Sharon M. McGroder

Dimensions and patterns of parenting were examined in a sample of 193 African-American single mothers with three- to five-year-old children receiving Aid to Families with Dependent Children (the control group in the Fulton County, Georgia, site of the Child Outcomes Substudy of the National JOBS Evaluation). Factor analyses of 20 parenting variables yielded three dimensions: Aggravation, Responsiveness, and Cognitive Stimulation. Cluster analysis was employed to ascertain how these three dimensions combined to yield patterns of parenting. Four patterns emerged: "Aggravated but Responsive," "Cognitively Stimulating," "Patient and Responsive," and "Low Responsive," indicating the variability in parenting patterns within this otherwise relatively homogeneous sample.

Next, 10 demographic, maternal, parenting support, and child variables were used to distinguish and predict membership in each of the four parenting clusters. Two discriminant functions emerged, accounting for 92% of the variance between parenting patterns. The first function represented maternal well-being (depression, locus of control) and distinguished "Aggravated but Responsive" and "Low Responsiveness" mothers (who tended to have poorer well-being) from the "Cognitively Stimulating" and "Patient and Responsive" mothers (who tended to have better well-being). The second function represented demographic characteristics (education, age-at-first-birth, duration on welfare) and distinguished "Aggravated but Responsive" and "Patient but Responsive" mothers (who, on average, had less than a high school degree, were not teen mothers, and were on welfare longer) from "Cognitively Stimulating" and "Low Responsiveness" mothers. These two discriminant functions allowed the correct classification of 49% of cases, a rate better than chance (33%).

Maternal well-being appears most important, demographics next important, parenting support less important, and child's age and sex not at all important for distinguishing different patterns of parenting, a finding consistent with Belsky's model of determinants of parenting. Finally, children's scores on the PPVT-R, Preschool Inventory, and Personal Maturity Scale were related to parenting pattern. On all three child development measures, children with "Aggravated but Responsive" or "Low Responsive" mothers scored lower than children with "Cognitively Stimulating" mothers. In addition, children with "Low Responsiveness" mothers scored lower on school readiness than children with "Cognitively Stimulating" or "Patient and Responsive" mothers.

In sum, mothers with a relatively external locus of control and high depression scores tended to exhibit patterns of parenting characterized by average or above-average levels of aggravation, and their children performed more poorly on measures of school readiness, verbal ability, and personal maturity. This may be a subgroup of mothers who are less likely to withstand the strains of hardships that accompany poverty, whose children can benefit from compensatory programs like Head Start, and whose vulnerability may require special attention by case managers enrolling these mothers into mandatory work-welfare programs.

Variations in Parenting and Child Outcomes among African American Adolescent Mothers and Grandmothers *Eurastine Brown, Tom Luster*

Presenters: Eurastine Brown

It is not surprising to find that a meaningful proportion of Head Start children are born to adolescent mothers and/or are being reared by their grandmothers. Successful transitions to parenthood can be a challenge; however, not all adolescent mothers and children are at risk. Some adolescent mothers make successful transitions to parenthood either alone or with the help of their own mothers. Traditionally, African-American grandmothers have assumed a major role in the rearing of their grandchildren, especially those born to adolescent mothers. Although past studies exploring adolescent family contexts have been constrained by the lack of integrated information on both family demographic and background characteristics and family processes, variations in parental and child competence have begun to be examined.

This investigation examined relations among demographic and contextual factors as well as family processes in families with children born to adolescent mothers and those being reared by their grandmothers. Participants were 346 African-American caregivers with former Head Start children (29 sites throughout the United States) who contributed data for this investigation (National Head Start/Early Public School Transition Demonstration Project). Adolescent maternal status was generated retrospectively. That is, adolescent status was given to mothers who were adolescents at the time of their child's birth. Of all the participants, 261 mothers were adolescents (less than 20 years of age) at the time of their child's birth and 85 were grandmothers.

Our analyses of national data on former Head Start African-American children included an examination of relations among 1) child and parent characteristics; 2) parental status and health; and 3) family contexts including family routines and parenting style and attitude. Grandmothers were more likely to report being in good health and to be rearing their granddaughters. A non-significant trend in the same direction was found for depression. No differences were found for employment status, but former adolescent mothers were more likely to receive food stamps and WIC. Children being reared by their grandmothers versus former adolescent mothers were in more stable and less mobile households. A greater number of adults were also residents in these households. However, these children were also more likely to be in households with a greater number of other children in residence.

When examining family routines, children being reared by former adolescent mothers were less likely to have regular chores, to complete their homework at the same time each day, and to check in with one another. Finally, variations in parenting style were not revealed for ratings of nonrestrictive attitudes and consistency. Caregivers did differ in their ratings of nurturance and responsiveness to their child. Although grandmothers rated higher on nurturance, former adolescent mothers rated higher on responsiveness to their child. Significant differences were also found for the discrete items measuring consistency. In sum, complex variations exist within ecologies of adolescent parentage and grandparent contexts. Future research will continue to increase our understanding of Head Start children and their families.

An Affective, Interpersonal Approach to Enhancing Mother-Child Relationships: Application and Efficacy *Sara Gable*

Presenter: Sara Gable

Developmental theory and research suggests that sensitive mother-child relationships are associated with child well-being during the first five years of life. Past research suggests that effecting positive change in maternal-sensitive responsiveness is possible. Thus, the goal of this study was to assess the efficacy of a 16-week child abuse prevention curriculum that addresses, in part, improving parenting skills and increasing the affective rewards of being a mother.

Results from a mother-child observational task conducted with experimental and control subjects before and after the treatment were presented. Participants were 52 ethnically diverse women and their 18- to 59-month-old children. Potential subjects were first screened at a local WIC clinic. Eligibility criteria for the study included women who 1) were the primary caregiver of a child between the ages of 18 and 59 months; 2) spoke English as a first language; 3) had no current Child Protective Services Caseworker; 4) had reported use of physical discipline with their child (e.g., spanking, slapping hands); and 5) experienced anger during the course of routine discipline encounters.

After the women were recruited into the study, pretest data were collected during two 2.5 hour home assessments. Subjects were then randomly assigned to the experimental or the control group (women were matched on the basis of race and the target child's age). The experimental group attended 16 weekly group therapy sessions and had a corresponding, individualized home visit; the control group received no intervention. Posttest data were collected after the intervention during two 2.5-hour home-based sessions. At pre- and posttest, the dyads participated in a semistructured, in-home task that required mothers to keep their child performing a boring, repetitive task (i.e., drawing circles) for 10 minutes with a set of attractive distractor toys in reach. Audiotapes of the interaction were transcribed verbatim and maternal and child talk were broadly classified; maternal discourse was considered in terms of control style and child discourse in terms of task compliance.

Although in both groups all maternal discourse evidenced across-time change toward being more child oriented and less parent oriented, one maternal conversation style—child-oriented verbal control—revealed a significant Time x Group effect. As compared to the control group, mothers who participated in the 16-week preventive intervention more frequently redefined the task in a cognitively challenging manner, offered positive incentives, and assisted their child in task-acceptable ways ($F(1,50) = 4.36, p < .05$). Similar results were found for children's conversation. Children of treatment mothers conversed in a neutral manner (as opposed to complaints and defiance) more frequently after the 16-week intervention than did control group children ($F(1,50) = 3.40, p < .10$).

Results suggest that the preventive intervention effected positive change in the level of sensitive, responsive behavior mothers provided for their children. Moreover, children's acceptance of maternal control and compliance with the task, as represented by neutral conversation, was indirectly positively affected by the treatment. Implications for reducing the risk of child abuse through parent-child relationship-enhancing interventions were discussed.

Implicit Theories of Intelligence: Relation of Parents' Beliefs to Children's Expectations

Claudia M. Mueller, Carol S. Dweck
Presenter: Claudia M. Mueller

The impact of adults' implicit theories on their parenting strategies and their children's beliefs and expectations is examined. Implicit theories are defined as beliefs about the nature of personal characteristics (e.g., intelligence and morality) and are divided into entity and incremental views. An entity theory defines a characteristic as a fixed trait that cannot be changed. An incremental view defines a characteristic as subject to change through effort.

We explored the notion that holding a fixed versus malleable view of specific characteristics leads parents to react differently to behaviors exhibited by their children. Specifically, we hypothesized that implicit theories predict adults' preferences for authoritarian versus authoritative parenting strategies. Entity theorists' belief in fixed traits was thought to result in a preference for rigid, authoritarian parenting, while incremental theorists' belief in malleable characteristics was expected to lead to a preference for flexible, authoritative strategies.

Further, we examined whether differing parenting strategies lead to the formation of distinct beliefs and expectations in children. Entity theorists, who prefer rigid parenting policies, were hypothesized to lead children to expect more negative adult responses to mistakes than incremental theorists.

Seventy-eight mothers and their kindergarten-age children participated in this study. Mothers completed a questionnaire containing statements about implicit beliefs of morality and intelligence, authoritarian and authoritative parenting practices, and ease of judging others. Parents responded to each statement on a scale of one (strongly disagree) to six (strongly agree). Children were read a story containing a failure situation and were asked to role-play the responses of teachers and parents to their mistakes. They were also asked to make judgments of others.

As predicted, entity theorists endorsed authoritarian parenting practices significantly more strongly than incremental theorists. Adult entity theorists were also found to feel significantly more able to make rapid judgments of others than incremental theorists.

A significant difference was found in children's expectations of teacher responses. Fifty-six percent of entity, but only 11% of incremental, children expected negative reactions from their teacher after failure ($X^2(1)=12.00, p<.001$). A trend was also found for entity theorists' children to make rapid, global judgments of others ($X^2(1)=2.83, p<.01$).

We hypothesized that children form their expectations and theories about the world in part from their relationships with parents. Our finding that both adult entity theorists and their children tend to judge others rapidly provides evidence that this overlap of beliefs occurs.

Our results also suggest that entity and incremental theorists' parenting styles play a role in transmitting these beliefs and expectations from parents to children. We believe that parenting strategies adopted by adults might shape not only their short-term interactions with their children, but also the long-term views those children hold. Our finding that children of entity theorists expect more negative responses from adults after failure provides support for the notion that parenting practices affect children's beliefs and expectations.

Future investigations should focus more closely on how these strategies may influence the development of theories and expectations in children.

Parenting, Parent Education, and Parent Involvement

The Relationship between School Climate, Parent Characteristics and Belief Systems, and Parents' Involvement in Their Children's School

Carol Seefeldt, Kristin Denton, Alice Galper

Presenters: Carol Seefeldt, Kristin Denton, Alice Galper

A current effort to keep Head Start parents involved in their children's education once children enter the public school is the Head Start/Public School Transition Demonstration taking place in 31 states. This study examines the relationship between school climate, parental characteristics and belief systems, and parents' involvement in their children's school in one Transition Demonstration. The questions were: 1) what level of parent involvement do former Head Start parents report; 2) does participation in a Transition Demonstration affect the level of reported parent involvement; and 3) what is the relationship between school climate, parental characteristics and belief systems, and parent involvement?

Eight schools in a suburban public school system are participating in the Transition Demonstration. Two clusters of four schools each were randomly assigned to either Demonstration or Comparison status. Demonstration schools receive a Head Start-like program focusing on parent involvement, developmentally appropriate classroom practices, social services, and health support. Data were obtained from two cohorts of Head Start parents. There were 105 parents in Cohort One and 130 in Cohort Two. Parents were individually interviewed, and information was collected on employment, help with children, and ethnic background. About Being a Parent, a measure of parental beliefs about self-efficacy, the School Climate Survey, and a four-item Parent Involvement Questionnaire were also administered.

On a four-point scale, the results showed that former Head Start parents report talking with their children almost every day ($M = 3.87$); participating in school activities ($M = 1.79$), volunteering in their children's school ($M = 1.52$); and keeping in touch with their children's teacher ($M = 2.07$) about one to three times per month. One-way analysis of variance indicated there were no significant differences in reported parent involvement between parents in the Demonstration or Comparison groups.

The relationship between parent involvement and parental and school characteristics was examined through separate stepwise regressions on each parent involvement item controlling for ethnicity and current employment. Parental self-efficacy ($b = .18$) predicted how often parents talked with their children about their school day ($F = 5.34, p < .05$). Both parental beliefs of self-efficacy ($b = .24$) and parents' perceptions of school climate ($b = .14$) predicted how often parents participated in school activities ($F = 5.16, p < .05$). Help with child care ($b = -.18$) and parents' perceptions of school climate ($b = .21$) predicted how often parents volunteer in their children's school ($F = 4.50, p < .05$). Parents' beliefs of self-efficacy ($b = .29$) predicted how often parents keep in touch with their children's teacher ($F = 14.62, p < .001$).

Former Head Start parents appear to be moderately involved in their children's education at the end of kindergarten. Demonstration and Comparison parents did not differ significantly in parent involvement. This may be due to competing programs in the Comparison schools, or the fact that this was the first year of the Demonstration. As the most consistent predictor of parent involvement was parental efficacy, it seems that programs interested in involving parents might focus on enhancing parents' beliefs about their own efficacy.

Development of a Home Visit Model for Improving Health Care Utilization and Parenting Skills *Kathy S. Katz, Phyllis Sharps, Susan Schneider*

Presenter: Kathy S. Katz

Pride in Parenting is one of the study protocols of the NIH-DC Initiative to Reduce Infant Mortality in Minority Populations. This research initiative in the District of Columbia is a city-wide collaborative effort among the major medical institutions. Pride in Parenting was designed to test the effectiveness of a combined health and developmental education model of early intervention for mothers delivering an infant with no or limited prenatal care. Poor prenatal care serves as a marker for poor pregnancy outcome.

Pride in Parenting is a one-year intervention beginning at hospital discharge. The design includes two combined intervention components: 1) home visiting; and 2) parent-infant play and discussion groups. Mothers are randomized to either the combined intervention or a usual-care hospital social work follow-up. Outcome variables include measures of family health care utilization, parenting knowledge and attitudes, infant development, and mother-child interaction.

Home visiting has been a long-standing strategy for providing outreach to mothers in need of guidance in parenting. The approach has received renewed support from a number of national task forces addressing infant mortality. Home visiting interventions vary in a number of features: 1) the objectives of the intervention; 2) the characteristics and training of the home visitor; and 3) the timing, frequency, and duration of the visiting program. Features of previous successful home visiting models, the Elmira (NY) Study, the Resource Mothers Project, the Abecedarian Program, and the Infant Health and Development Program, were incorporated in the home visiting model developed for Pride in Parenting. These features include 1) lay home visitors of similar ethnic background to the study population; 2) weekly home visits from hospital discharge until the infant is five months old and biweekly visits to age one; 3) preparation of home visitors through an intensive 45-day training curriculum; 4) delivery of a specifically designed home visit curriculum with an individual plan for each visit; and 5) a curriculum focusing on improving family health care, child development, social competence, and planning for the future.

Curriculum topics for the home visits in the Pride in Parenting program include issues related to women's health, newborn care, contraception, problem solving, stress management, home safety, developing a support network, budgeting, establishing daily routines, finding community resources, child development, child disciplining, and planning for the future. Support materials for each discussion topic have been selected by a health educator for cultural sensitivity and readability by individuals with low literacy.

Benefits of the program are expected in improving health behaviors and child management strategies in this high-risk urban minority population. Collaborative partnerships among researchers across the participating institutions will hopefully be sustained for future comprehensive community-based interventions.

Parenting, Parent Education, and Parent Involvement

Factors Related to High and Low Parent Involvement in a Head Start Program

Sally Hruska

Presenter: Sally Hruska

Parent involvement is central to Head Start, but there have always been differences in the degree to which parents participate, and the degree to which the ordinary Head Start program provides social support is unclear. For this study, contrasting groups of parents were chosen from opposite ends of a continuum of volunteer hours, and data about a range of family and community-service variables were gathered from a single interview with each parent. The sample was selected from the 157 (of 219) enrolled families with a four-year-old child in the program year 1989-90 Alger-Marquette, Michigan Head Start Program. Classroom volunteering accounted for the great majority of the hours donated.

In comparison with 28 parents least involved, the 38 parents with the most hours of involvement were more likely to do other volunteer work outside Head Start ($p < .001$); to participate in other organizations ($p=.04$); to have less negative views of the human service systems ($p=.03$); and to have received prior services from quasi-family-support programs such as church, the Women's Center, the domestic violence shelter, a health home visitor, or mental health counseling ($p=.02$).

Although parent involvement groups did not differ by marital status, age, number or gender of children, or participation in educational programs or work (part-time and full-time work were not discriminated), high volunteers were more likely at some point to have dated at least one person other than the father of their child ($p=.002$). They were also more likely to have brought their child's younger sibling with them when they volunteered in the classroom ($p=.004$), during this or a previous year in Head Start.

Scores of the Parenting Stress Index did not differ between high and low participation groups, but subgroups of parents who experienced maltreatment as children (measured by a developmental history questionnaire) also experienced greater parenting stress ($p < .05$), regardless of level of participation in Head Start.

Both groups of parents valued Head Start as a child development program, but high participants were more likely to value it as an adult support program for themselves as well. Factor analysis identified eight items recognizable as a family support cluster, including "Head Start helped me set some goals for myself"; "Head Start helped me to grow in some important ways"; and "Being in Head Start is like being part of a family." These aspects of the program were more important for parents who were very involved ($p < .001$).

Highly involved parents with histories of maltreatment contributed heavily to this finding; there was even a marginally significant difference between them and the other highly involved parents ($p=.05$).

At the extremes of participation, parents differed in their level of connectedness to the community and the way they experienced the Head Start program their child attended. For some it was a child development program and for others a broader family-support program. The open invitation to bring a younger sibling on volunteer days may be a productive parent involvement technique.

BEST COPY AVAILABLE

Parenting, Parent Education, and Parent Involvement

Barriers to Parent Involvement in Head Start Programs *Nicole M. Driebe, Moncrieff Cochran*

Presenters: Nicole M. Driebe, Moncrieff Cochran

Head Start stresses the partnership between the family and the early childhood program, a relationship that is becoming increasingly important in a society where more women are entering the labor force and the number of children receiving nonfamilial child care continues to rise. However, despite this major emphasis on parental involvement, little research has documented Head Start's impact on families. In addition, the research that has been done is outdated, and is limited primarily to descriptions of how many parents are participating and what parents think about the Head Start program. Despite the problems related to research on parent involvement in Head Start, there is one conclusion about which experts seem to agree: When parents get involved in their children's Head Start program, it is beneficial to the children, the program, and the parents themselves.

If involvement makes a difference, then two important questions deserve attention: 1) are there parents who are not participating in the parent involvement opportunities provided by Head Start; and 2) what barriers might prevent such parents from becoming involved?

Barriers to parent involvement in three rural, upstate New York Head Start Programs were investigated. Two telephone interviews, six months apart, were used to obtain information on barriers to and level of involvement. Head Start's standard parent involvement form and participant observation by the first author were used to document amounts of involvement between pre- and posttests.

Analysis of the results revealed that high hours of employment, and the somewhat greater financial resources that accompany employment, may compete with parent involvement as currently prescribed by Head Start. Qualitative analysis of parent interviews also revealed that changes in household composition accompanying program participation, such as the birth of a baby or a divorce, could also serve as potential barriers.

One conclusion to be drawn from this study is that certain kinds of families "fit" the present Head Start model of parent involvement better than others. As the program is currently structured, there are four basic areas in which parents can participate: policy council, classroom participation, activities developed by parents for parents, and parents working on activities with their children. Although all four options are presented to parents, classroom participation and parent meetings are emphasized most strongly. The model of parent involvement that results consists essentially of parent meetings plus classroom volunteering. Families with certain characteristics fit into this model quite nicely: those that include two parents, with one parent spending most of his or her time taking care of the home and the children. Fewer and fewer American families conform to this family form, however, and this is especially true for low-income families.

One way to increase involvement by less "traditional" parents would be to "tailor" involvement activities to better suit differing family characteristics and circumstances. This would require broadening the Head Start definition of parent involvement to include any type of planned activity in which the parent is actively involved with or on behalf of her child. To support this broader definition of involvement, Head Start might need to provide a variety of additional resources for parents.

Parenting, Parent Education, and Parent Involvement

Developing Interactions that Nurture and Teach 'At-Risk' Mothers: The PACT

Program *Luminitza Shapp*

Presenter: Luminitza Shapp

PACT is a parenting training program of Elwyn, Inc. Families are referred to PACT as an alternative to out-of-home placement of children. The PACT model combines home-based and center-based training. Parents attend for a six-month cycle. Each parent receives a total of 13 home-based sessions and 13 center-based group sessions. During any one cycle, PACT services between 20 and 25 families. The participants are of mixed ethnic backgrounds, live on public assistance, and are marginally employable. Their ages range from 18-44, with an average age of 28; the average age of children is 29 months. The mission of the program is to provide training in adequate parenting practices by addressing issues of organization, routine, discipline, and emotional and educational needs of children.

Mediated Learning Experience was selected for development of the PACT curriculum for several reasons: 1) the flexibility allows for a high degree of individualization; 2) the focus is on developing a "frame of mind" rather than lists of specific activities; 3) the ideas are translatable to language that parents can understand; 4) it is conducive to incidental learning, as well as formal instruction; 5) the outcomes coincide with the goals of the program, regarding the development of parents as active learners and partners in the discovery of how to facilitate the development of their children; 6) the approach crosses over all program components, including nutrition, safety, health, family planning, sexual abuse, discipline techniques, and self-improvement; 7) MLE helps parents focus on the process and not outcome of interactions; and 8) MLE puts the parents in charge of their own behavior and promotes the learning of principles to apply in a wide variety of situations.

The components of Mediated Learning Experience have been worked into three curriculum units. Intent, meaning, transcendence, and contingent responsivity are incorporated into "We Understand One Another"; affective involvement, sharing, and praise/encouragement are addressed in "I Love You and I Get A Kick Out of You"; intent, challenge, psychological differential, and task regulation are the focus of "I am Helping You Grow." Each unit also includes discussion of issues of child development, self-esteem, communication, discipline, and advocacy.

The parents are videotaped in interaction with their child during 30-45 minutes of play time (Parent/Child Activity) followed by a group discussion that consists of reviewing the tape, comments, and completing the curriculum guide. Home-based sessions provide follow-up on the discussions, as well as an opportunity to address individual issues related to the cause of the referral of the parent to the project. Program evaluation includes parent responses to several questionnaires and pre- and postprogram assessment of risk from the referring agency.

Results of pre- and postprogram administration of these measures show an increase from low to intermediate levels in self-esteem, a decrease from 100-28% of under- or overestimation of the children's developmental age, a decrease from moderate to low levels in risk assessment, and an increase in knowledge of child development for all but one parent (average score increase from 58.5-61.3). Out-of-home placement of children correlates with the risk assessment only postprogram.

Father and Grandfather Involvement in Childrearing and the School Performance of Ojibwa Children: An Exploratory Study *Edith Williams, Norma Radin, Kip Coggins*

Presenter: Edith Williams

This exploratory study examined the relationship between the quantity and quality of Ojibwa fathers' and grandfathers' ($N = 19$) involvement in childrearing and their children's (age 3-11) school academic performance and social adjustment. The sample was selected from families living in Michigan's Bay Mills Ojibwa Community. The family unit consisted of a mother, stepmother, or live-in female significant other; a father, stepfather, or live-in male significant other; closest grandfather; and a target child. Data collection included completion of a questionnaire through separate interviews with the mothers, fathers, and grandfathers.

Independent variables included 1) a single question regarding the percentage of time the (grand)father was the child's primary caregiver when the child was awake, not in school, away from home, or with a sitter; 2) the Paternal Involvement in Child Care Index of overall (grand)father involvement; and 3) the Parent Perception Inventory, a measure of (grand)father nurturance. Dependent variables included 1) school report card grades; 2) standardized test scores; 3) Achenbach's Teacher Report Form of the Child Behavior Checklist; 4) the Native American Adaptive Functioning Check List; and 5) teacher predictions of future community involvement. Pearson product moment correlations were computed between the independent and dependent variables. Analyses were completed for the group as a whole and for boys separately.

Fathers' amount of involvement as a primary caregiver was associated with better academic and social competence in school, especially for boys. The economic structure of the Bay Mills Community is based on fishing and the local Casino. Men can spend many long hours away from home and family. It is possible that this arrangement fostered a family social structure where the amount of time fathers spent with their children in primary caregiving, rather than his overall involvement, was a more powerful influence on the children's, particularly their sons', development.

The children of less nurturing fathers appear to have a higher academic performance and are more socially adept. Possibly Baumrind's conceptualization of authoritative parenting, i.e., high levels of responsiveness and demandingness, which leads to greater social competence in children, was not prevalent in these Native American families. With great Native American value placed on parental noninterference in children's lives, the level of demandingness was likely to be low. The combination of high levels of affection/responsiveness and low demandingness came closer to Baumrind's description of permissive families, which does not generally lead to school success. Perhaps our results pertaining to paternal nurturance would have been different had the children been attending a school taught by Native American staff and filled with Native American children.

There is much stronger association of grandfather involvement with the children's adaptation to Native American codes of social behavior than with the children's overall social adaptation. This is in keeping with the literature, which states that proper codes of Native behavior are taught to children by their grandparents. However, the results suggest that for this influence to be exerted the grandfather must be a critical person in the child's upbringing.

Parenting, Parent Education, and Parent Involvement

Case Study: Development of a School-Based Parent Center for Low-Income New Immigrants

Diana Buell Hiatt, Tom Johnstone

Presenters: Diana Buell Hiatt, Tom Johnstone

The purpose of this in-progress case study (June 1993 through June 1996) is to determine viable ways in which low-income parents/guardians would become involved with their child's school. In addition, the study is collecting evidence on barriers and supports toward implementations of various parent involvement activities. This study is based upon Apps' work, which states that application of transformative learning theory by action researchers would reveal existing influences within the school situation that would determine the underlying perceptions of adult learning activity and provide insights into new conceptions.

The selected methodology is action research involving an array of types of data collection. Data collection includes researcher weekly activity logs, records of formal meetings, attendance records, parent surveys, and interviews with teachers, staff, students, and parents at benchmarks in project development.

The school under study is located within Lennox, a one-square-mile, inner-city Latino southern California community. The district is populated with Latino families who in many cases live two to four families per small four-room California bungalow-type dwelling. Data on the children from these homes indicated a high rate of transiency from school, and 34.4% of students graduated from high school in 1992. Ninety-two percent of parents are Latino and, of those, a high majority are limited-English-speaking parents. Therefore, selected outcome factors of the study include student transiency and parent and student perceptions of school climate.

This study accepted Goodlad's assumption that the principal is the key gatekeeper of change at the school site. The school principal was self-selected to complete weekly logs of his activities with parents or parent-related events and to reflect on those activities with this study's director.

Preliminary findings report that statistical records indicate significantly more parents were involved in parent center activities at the kindergarten level than in previous two years. The principal as key change agent was pressured by district and state mandates to direct his energies in other ways. The principal's belief is that parent involvement and the parent center are critical components to student achievement. This belief, as indicated by the principal, maintained the momentum to introduce new activities and let others die. Data from staff and parent interviews are being collected through September. Portions of this data, student data, and the log records will be analyzed and presented according to Epstein's six types of parent involvement.

Assessing Information Needs of Parents: Evolution of an Instrument

Nancy M. Gerard, Andrea B. Smith, Linda L. Dannison

Paper not available

Academic Resiliency among Head Start Graduates: What Distinguishes High Achievers from Average Achievers?

Judith McCullough, Laura Diaz, Norman F. Watt

Presenters: Judith McCullough, Laura Diaz, Norman F. Watt

The cross-sectional study proposed in this poster is the pilot phase for a larger longitudinal effort. Through the data collected during this first phase of the Resiliency Project we can begin to identify protective factors that promote academic excellence among children traditionally portrayed as "at risk" for a number of maladaptive outcomes (including academic failure and dropping out of school). Research has most often focused on the academic deficits of these children and risk factors associated with the increased prevalence of these deficits. It is equally important for the literature to reflect that some "at-risk" children achieve academically despite socioeconomic obstacles, and to explore protective factors that may contribute to resilience. By identifying and tracking children who achieve in spite of "the odds," we may be better able to inform current interventions and plan future efforts to improve academic achievement and reduce the incidence of other maladaptive outcomes among children of poverty.

We are currently compiling a longitudinal database of Head Start graduates (since 1979) who have continued their education in the local public school system. Academic Resiliency, the focus of our study, is defined stringently: above average performance by a national standard (ITBS Reading Achievement scores at or above the 76th percentile).

It is our hope that by in-depth study of these achievers (as contrasted with average achievers, rather than low achievers), we can understand some of the factors that allow resilient children to achieve when most of their peers are not achieving, and emphasize the resourcefulness of children and parents who are more often depicted as being deficient. The specific aims of the project are 1) to identify the relative impact of different social influences on the academic achievement of "at-risk" children, including parents' overall and school-related support, peers' overall and school-related support, and the interactive effects of parental and peer support; and 2) to investigate how discrepancies between children's school-related values and the values of important others may positively or negatively affect academic achievement, especially when voiced parent/peer commitment to academic success differs from demonstrated parent/peer commitment to academic success.

The proposed sample for the study will be composed of 120 children between the ages of 8 and 18—60 high achievers (76-100th percentile ITBS Reading Achievement Subtest) and 60 average achievers (26-50th percentile ITBS Reading Achievement)—and their primary and secondary caregivers. The feasibility of finding participants who meet the above criteria is promising. Thus far, 6,939 Head Start graduates have been identified as being currently enrolled in the Denver Public Schools (61% Hispanic American, 28% African American, 8% European American, 2% Asian American, and 1% Native American; 49% female, 51% male). Of these, approximately 220 children across ethnic groups fall into the "high achiever group," and over 900 children qualify as "average achievers." Participating families will be recruited through the Denver Public Schools (DPS) and the Child Opportunity Program (parent organization of Denver Head Start) and interviewed in their homes. Average achiever and high achiever groups have been matched individually on ethnicity, gender, and grade in school.

Parenting, Parent Education, and Parent Involvement

Child Abuse Prevention: Parent Involvement in Community-Based Programs

Susan G. Cooper, Carol C. Torrey

Presenters: Susan G. Cooper, Carol C. Torrey

Child abuse and maltreatment continue to be a major issue for educators, child care professionals, and families throughout the United States. Family stressors resulting from single parenting, poverty, poor education, and single-teen parenting are associated with and contribute to child maltreatment. Subsequently, these family stressors affect the education and development of young children. To address the issue of child abuse, many communities have implemented adoption reform, kinship care, expanded family preservation programs, family resource centers, and parenting programs. As funding for programs continues to become more limited, communities need to identify the existing and accessible resources and evaluate their effectiveness.

Head Start programs are designed to serve the needs of the entire family of a child enrolled in the program. Head Start participants have been considered a potentially high-risk group for child abuse due to lower socioeconomic status, lower educational levels, and the young age of children enrolled in the program. The purpose of this study is to determine the relationship between parent/caregiver participation in a Head Start program and other selected family characteristics on the child abuse potential.

A random sample of parents ($n=219$) from 1,400 children enrolled in 11 Head Start centers in Southeast Louisiana completed a Child Abuse Potential Inventory (CAPI) and a Model Family Needs Assessment Instrument in fall 1995 and spring 1996. This geographical region of Louisiana has documented high child maltreatment rates, high child death rates, a significant number of births to single teens and single-parent families, high rates of children in poverty, and low graduation rates from high school.

Quantitative analyses of the CAPI scores were conducted to obtain preliminary results for this study. T-test calculations were utilized to determine if a difference existed between fall and spring Child Abuse Potential score on the CAP Inventory, and Pearson Product Moment Correlations were computed to determine relationships between income level, parent involvement, age, longitudinal parent involvement, and child abuse potential. Preliminary analysis revealed that initial CAPI scores were elevated for 26% of the participants, and the mean score for all participants was above the mean compared to a normative sample of 836 parents. Data also revealed a decrease in CAPI scores between fall and spring; however, the difference was not significant.

The results of the Pearson Product Moment Correlation revealed significant relationships between two variables and child abuse potential scores. A significant, strong relationship between income level and child abuse potential was demonstrated and a significant relationship was revealed between longitudinal parent involvement and fall-spring test score change. Comparison of CAPI scores for families who have children with and without disabilities revealed no significant difference between the groups.

Results of this research provide an additional resource for Head Start Centers to determine level and type of parent involvement that may lessen child abuse potential. Verification of an operating program that is successful in deterring child abuse would be an asset to document effective use of fiscal resources and would provide support for future funding requests. Further research may indicate program components and methodologies, which, if strengthened, could assist in the reduction of child abuse.

Cultivating Positive Family-Professional Partnerships: Single-Parent Involvement in Early Childhood Programs *C. Wayne Jones, Donald G. Unger*

Presenters: C. Wayne Jones, Donald G. Unger

The primary purpose of this study has been to facilitate the optimization of the delivery of family support services for urban, low-income single-parent families. Specific focus was given to the identification of factors that influence parent-professional relationships and family-related service utilization in early childhood programs. A sample of 218, primarily African-American, low-income single parents were recruited from 21 different urban early childhood programs, including EIPs, Head Starts, and At-Risk programs. Single-parent family structures were diverse, including solo-parent, three-generational, couple-headed, and kinship households.

In this nonexperimental, naturalistic study, parents were administered structured interviews both within the first 6 months of the child's school enrollment and again 8-12 months later. Parent-child interaction was observed and information was obtained about a variety of child, parent, and family characteristics. Between the first and second interviews, the nature and scope of parent participation was sampled every six to eight weeks both via program staff and calls to parents. Program environment was also measured.

Important insights about the nature of parent involvement were gained by examining the mechanisms by which parent-professional contact occurred, the type of services utilized, and program emphasis. Basic activities were defined as those that were routine and required by the program, while enhanced activities were those that were related to meeting the individualized needs of children and their families. Parents with children in At-Risk programs had a significantly higher number of total contacts with the school each month, and a higher percentage of these contacts involved enhanced services than either parents in EIPs or Head Start programs. This is attributed to the emphasis At-Risk programs place on parents as the main focus of change. For all three types of programs, there was a general decrease in parent-related service utilization over the first year of a child's enrollment.

Single parents who reported higher levels of parenting stress and family needs and perceived their children as difficult, utilized more parent-related services. In addition, the less perceived support single parents obtained from their mothers and/or their male partners, the more parent-related program services they utilized. The most critical program variable related to service utilization was the quality of the caregiver's relationship with the child's teacher.

The findings suggest that single-parent utilization of family support services in early childhood programs can be optimized by routinely considering the maternal grandmother and/or male partners in communications about program services, guarding against assuming the single parent is parenting alone or in a social vacuum. In addition, program policies should ensure that staff is provided with sufficient time and opportunities for regularly interacting with parents. For parent- and family-related services to maintain equal status within early childhood settings, it is important that a specific staff person be dedicated to the coordination of parent/family services. Lastly, cross-fertilization between different types of early childhood programs is recommended, since the needs of single-parent families in each of the programs appear to be more similar than different.

Parenting, Parent Education, and Parent Involvement

Adding Monthly Home Visits to a Center-Based Head Start Program: Effects on Teachers, Parents, and Children

Nancy Kling, Loraine Dunn

Presenters: Nancy Kling, Loraine Dunn

Theory and research support parent involvement as an effective means of enhancing children's development. Theory suggests that parent involvement in the form of teacher-led home visits should be an effective means of supporting children and parents. To empirically test this hypothesis, the current study utilized a pretest, posttest multiple treatment design to examine the potential benefits to children, parents, and teachers of adding eight monthly (September-April) child-centered home visits to regular center-based Head Start half-day programs serving four-year-old children. The sample consisted of 69 children, their mothers, and eight Head Start teachers. The treatment was composed of three groups: 1) the experimental group (N=26) received eight monthly home visits by the child's teacher or assistant teacher; 2) to control for the Hawthorn effect, a comparison group (N=22) received brief monthly home visits by university early childhood students; and 3) the control group (N=21) received the two required visits by their teachers.

The constructs measured included teachers' and parents' attitudes toward one another, mother's developmental expectations for her child's cognitive and social competence, the teacher's assessment of the child's self-competence, the child's perceived self-competence, and the mothers' perception of her role in her child's development. Independent variables were the treatment and family and teacher characteristics. Analyses of variance were computed to ascertain pretest differences among the treatment groups on the outcome variables. When there were pretest differences or significantly related family correlates, ANCOVAs were calculated. In the absence of pretest differences and family correlates, repeated measures ANOVAs were used.

Posttest analyses indicated that the home visits did not significantly influence children's perceptions of themselves, or the teachers' and parents' attitudes. The teacher's perception of the child's competence, the mother's expectations for her child's development, and the mother's perception of her role in her child's development were influenced by the home visits; however, the experimental group experienced less change than the comparison and control groups. These results do not support the premise that children's teachers need to be the ones who make the home visits or that previous research indicating individualized home visits are critical.

Problem-Solving Orientation and Involvement in a Family Empowerment Program

Kristin Riggins-Caspers, Karen Colbert

Paper not available

Operation Renew: An Eleven-Year Follow-Up of Sociobehavioral Development in Boys

Linda Pagani-Kurtz, Richard E. Tremblay

Paper not available

The Effects of Parents' Observations on the Development of Their Children's Abilities and Success in Kindergarten *Silvia La Villa*

Presenter: Silvia La Villa

Today, the role of parents in their children's education is a topic of considerable discussion in political, educational, and social arenas. One example is the parent involvement initiative launched by Secretary of Education, Richard W. Riley, in September 1994. This initiative promotes a partnership between the Department of Education and various organizations including businesses and churches, calling upon them to help enlist parents in the fight to improve schools. The problem investigated in this study was to determine the effects of parents' observations on the development of their children's abilities and success in kindergarten.

Parents are viewed as the first and most essential teachers in their children's lives. Trends indicate that parents must provide a secure environment in which language promotes learning and be involved in their children's love for learning.

This study used the High/Scope Child Observation Record as a means to 1) connect parents with their children's education; 2) connect parents with their children's teacher; 3) integrate the parent involvement and education components; and 4) provide parents with five areas of knowledge—child development training; strategies to document their children's behavior; skills for appropriate interpretation of observations; proficiency in using results for planning their children's educational paths; and strategies to work with teachers.

The procedures of this study supported the role of parents as learners, observers, practitioners, teachers, and parents. This is a comprehensive view of parent involvement, having parents at the center of development. Parents discover their strengths, potentialities, and talents and use these skills to benefit themselves and their families.

There are two basic findings in this study. First, there is evidence from the COR ratings by parents and teachers that there was a significant effect of time, measured across the COR scales. These data suggest that COR training influenced parents in their child development knowledge, their relationships with their children, and in turn, their children's abilities and success in kindergarten.

The second and most consistent finding is based on the scores of COR and NON-COR groups on the General Cognitive scale of the McCarthy Scales of Children's Abilities. The data demonstrated the COR group outscored the NON-COR group on the McCarthy Scales of Children's Abilities, particularly in the General Cognitive Scale.

It appears that use of the High/Scope COR increased parents' understanding of child development and their active participation in observing children's behavior. This study supported the use of an instrument such as the COR as an integral part of the curriculum and the involvement of parents as meaningful agents having positive effects on their children's success and abilities in kindergarten.

The suggested results support the short-term effects of using observational assessment as an influence that can have significant positive effects in the lives of children as learners. Long-term effects are indicated with the empowerment of children, parents, families, and communities by improving their understanding of how children learn and supporting their interactions with their children.

Parenting, Parent Education, and Parent Involvement

Using Collaboration and Small Groups to Increase the Effectiveness of Parenting Programs in Head Start

Andrea A. Zevenbergen, Jennifer O'Kane

Presenter: Andrea A. Zevenbergen

Parenting programs have been found to impact positively upon children's behavior problems, parents' attitudes about parenting, and parents' reports of parenting stress. Factors that have been found to predict nonresponse to treatment include socioeconomic disadvantage and parental social isolation. The recent work of Myers et al. and Webster-Stratton suggests, however, that parenting interventions with socioeconomically disadvantaged parents can be effective, if the interventions are designed to be culturally sensitive and/or utilize a collaborative model of intervention.

The present study examined the effects of a parenting program conducted in Head Start with Head Start mothers. This study differs from previous studies in that in the present study, the parenting intervention was presented through small groups, each comprised of two facilitators (one of whom was a Head Start parent) and three additional parents. It was hypothesized that group collaboration regarding treatment goals would be facilitated with small groups of parents. It was also hypothesized that the small group would facilitate the development of social support among group members.

The general content of the parenting program was developed through the collaboration of a university-based researcher and a Head Start parent. The program was organized such that six topics regarding parenting were discussed over the course of a six-week program. Although a loose plan was developed to discuss one topic each week, the goals and agenda for each session were determined by the group on a week-to-week basis. The goal of this flexibility was to increase parents' feelings of control regarding the program content, with the ultimate goal of positively impacting parents' thoughts and feelings of general self-efficacy. A second principle utilized in the group was that of parents working together to generate solutions to their children's behavior problems, with the researcher serving as group facilitator rather than leader.

Thus far, nine parents participating in three parenting groups have taken part in this intervention. The racial composition of the sample of mothers thus far has been 67% African American, 22% Latino, and 11% European American. To assess the effects of the parenting group, parents completed questionnaires prior to and subsequent to participation in the intervention. Preliminary analyses suggest significant changes in target child behaviors subsequent to the parenting intervention. Moreover, preliminary analyses revealed positive changes in parents' feelings of self-efficacy regarding their parenting abilities subsequent to the intervention. Discussion with participants revealed that the majority felt that the group was a source of social support to them, with regard to both parenting and general issues. Although the foregoing pilot study was not conducted using an experimental design (i.e., there was no control group), preliminary analyses suggest that using a small-group, collaborative approach within parenting interventions can have positive effects upon Head Start children's behavior problems and parents' feelings of self-efficacy.

Parent Involvement in COGNET Schools: Application of Mediated Learning Experience

Katherine Greenberg, Nancy L. Tarsi, Marianne Woodside

Presenters: Katherine Greenberg, Nancy L. Tarsi

The Cognitive Enrichment Network Education Model (COGNET) is a program designed to establish a parent/teacher learning-to-learn partnership through which high-risk children can develop thinking skills and achieve greater school success. Approved by the National Diffusion Network (NDN) in 1995, COGNET helps children become effective, independent, life-long learners who are able to adapt to an ever-changing world and act as responsible members of society by building a foundation for effective critical thinking through the use of cognitive processes and affective/motivational approaches. The COGNET model teaches children to learn how to develop their own strategies in virtually any academic or nonacademic setting. COGNET, which is based on compatible theory and supported by research, combines a unique approach to teaching children how to learn with best practices in education, including challenging, project-oriented inquiry and cooperative learning approaches.

Key components of COGNET include a mediated learning classroom approach that incorporates ten Building Blocks of Thinking, eight Tools of Independent Learning, and a process-oriented child-centered classroom atmosphere; parent/school learning-to-learn partnership; a supportive implementation network; and theory and research-based practices. This presentation reflects two separate studies in rural and in urban populations, respectively.

The purpose of conducting this research was to evaluate the effectiveness of parent/school learning-to-learn relationships in COGNET schools, as well as to understand more fully the unique challenges in promoting community involvement in poor neighborhoods. In addition, the rural study focused on comparing COGNET parents with a group of nonparticipating parents. The importance of this information is seated in literature amassed over the last 20 years that reports the strong positive relationship between parent involvement in schools and student achievement. This is of particular significance for the populations we serve, in that the school dropout rates for poor children are notoriously high.

The urban study conducted interviews and focus groups with parents in four different urban sites. Thematic analysis of the individual and group conversations revealed important information about parents' experience of self-improvement, hopes and expectations for their children, and commitment to increased involvement in their children's schools. Relationships with teachers and other parents were found to be of prominent concern to the parents, and feedback about the COGNET program was offered. The rural study involved interviews with groups of parents in COGNET and comparison schools.

Findings revealed parents' feelings of increased understanding of school and school work with respect to helping their children more. While parents indicated that their initial introduction through permission letters to COGNET was confusing and incomprehensible, they uniformly came to trust the program and request more involvement and services from the COGNET program. Most importantly, parents from COGNET schools came to see themselves as capable of assisting their children in learning. Both studies provided opportunities to learn and to refine the elements of the COGNET program.

Parenting, Parent Education, and Parent Involvement

Pride in Parenting: Multidisciplinary Initiative to Reduce Infant Mortality

Ayman El-Mohandes, Doris McNeely Johnson, Davene White, Lawrence Grylack

Paper not available

The NIH-DC Initiative to Reduce Infant Mortality is a unique, city-wide research effort involving academic and clinical institutions in collaboration with the community. The Pride in Parenting Program of the Initiative is a multidisciplinary study designed to improve the parenting skills and health care utilization of mothers deemed at risk because of failure to seek prenatal care during pregnancy.

The Effects of Neighborhood Context on Parenting Priorities of Families Living in Three Urban Neighborhoods

Margaret O'Brien Caughy, Robert Aronson, Patricia O'Campo, Peter Schafer

Paper not available

Qualitative and quantitative data regarding parenting priorities from surveys of 881 individuals in Baltimore were used to examine how parenting attitudes and priorities vary with neighborhood characteristics. Results of multilevel analyses of neighborhood-level and individual-level effects on parenting in these three urban communities are presented.

Perceptions of Involvement and Respect in Parent Education: An Empirical Investigation of Empowerment Concepts

Sally Schwer Canning, John Fantuzzo

Paper not available

An Empowerment Parent Education Strategy (EPE) was devised in which participants collaborate in the creation of their own workshop content and format. EPE is compared with a conventional parent-education condition. One hundred twenty-six Head Start parents perceive significantly higher levels of parent involvement and facilitator respect in the empowered workshops.

Promoting Continuity of Programs That Make a Difference: Teachers Become Leaders

Carolyn Scott, Mary J. Baskerville, Tina Pantan, Barbie Nadal

Paper not available

Training Teachers: The Process of Learning in Child Development Associate (CDA)

Candidates *Lisa A. McCabe, Moncrieff M. Cochran*

Presenters: *Lisa A. McCabe, Moncrieff M. Cochran*

Since 1973, Head Start staff have been training to become better teachers through the Child Development Associate (CDA) National Credentialing Program. This study investigated the training process of early childhood educators by examining what factors in CDA training promote and/or hinder learning. Ten CDA candidates were closely followed as they progressed through a nine-month CDA training. Data were collected through in-depth interviews and participant observations.

The constant comparative method of data analysis revealed factors that both promote and hinder the learning process in early childhood educators. On the positive side, class discussions, during which candidates shared stories of their own work experiences with young children, benefited the candidates in four ways. First, CDA candidates gained access to a wealth of information about early childhood education theory and practice from each other. Second, candidates had the chance to practice their oral communication skills in a safe environment of people that they knew. Third, class discussions provided a unique opportunity for child care providers to problem-solve with other professionals. Lastly, regular contact with other child care providers allowed candidates to empathize with each other, as well as to have their own feelings validated.

Another key ingredient in the candidates' learning process was the instructor of the CDA course. This instructor was particularly effective because she fulfilled multiple roles for the candidates. First, she excelled in her role as teacher because she taught by presenting new ideas using an engaging multimedia approach that was nonthreatening and non-judgmental. Second, the instructor played the role of consultant in that she advised the candidates when they ran into difficulties on the job. Third, the instructor acted as an educational counselor. When candidates became discouraged about pursuing their CDA, the instructor was able to persuade them to continue through encouragement and a flexible, accommodating teaching style.

Factors that hindered the learning process were also evident in this investigation. Two personal barriers, a negative attitude and a lack of self-confidence, negatively impacted candidates' learning experiences. A negative attitude, a consequence of candidates forced into taking the CDA program for fear of losing their jobs, resulted in students beginning the course unmotivated and resentful. A lack of self-confidence hindered learning because it caused candidates to doubt their abilities to complete CDA training, leading them to consider quitting the program.

Lack of support from employers presented a second barrier to learning. Throughout the CDA program, employers typically failed to recognize the accomplishments of their staff with an increase in salary or through public affirmation in forums such as center newsletters. These results suggest two conclusions. First, the formalized group instruction portion of the new Council Model for CDA training is an essential part of the learning process because it facilitates class discussions and regular contact with an instructor, both of which promote learning. Second, CDA instructors must be willing to fulfill multiple roles for candidates in order to meet the needs of individual students, overcome personal barriers, and encourage the completion of training programs like the CDA.

Professional Development

Factors Affecting Teachers' Decisions to Report Child Abuse and Neglect

Sandra L. Starkey

Presenter: Sandra L. Starkey

Because the majority of abused and neglected children are students in our schools, teachers are often the first to notice the signs of abuse and neglect. Although reports increased 153% between 1979 and 1990, few educational personnel actually reported child abuse; only 24% reported directly to Child Protective Services (CPS).

The difficulty, according to Basharov, is that "although the mandate may seem straightforward, definitional vagueness and evidential ambiguity combine to make the decision to report (or not to report) a difficult and often stressful one." Another difficulty for educators is a lack of faith in CPS, because of the number of reports "where 'nothing was done' because of the lack of hard evidence," leading teachers to believe they need proof.

The research presents a confused scenario. On one hand, teachers are guilty of Type I errors of omission (failing to report when abuse is evident) because they do not understand the laws, believe they need proof, or recognize the most severe cases. On the other hand, CPS appears to accuse teachers of Type II errors of commission (reporting abuse when none exists).

Previous research relied on checklists and hypothetical vignettes, but none investigated the decision-making process; therefore, the focus of this study was to investigate the complexities of the decision-making process and the factors teachers take into account in determining whether or not to report suspected child abuse and neglect. A qualitative research design was chosen in order to understand teachers' experiences and "to assure the teacher's voice is heard loudly and articulately." The 30 participants described in a written narrative a situation in which they had to make a decision of whether or not to report child abuse or neglect and completed a demographic survey.

The stories of these teachers indicated that although educators feel a sense of obligation and responsibility to report, the decision is difficult and complex. The teachers described their experience as frustrating, painful and difficult and expressed feelings of guilt, sadness, and fear. Concern for the safety of the child and fears of reprisal influenced their decisions as teachers described being confronted and even threatened by irate parents.

The support of school personnel was the most beneficial factor leading teachers to report suspected abuse or neglect. Where school policies were in place and suspicions reported to a definite person, teachers had the least difficulty making the decision. Teachers in schools without policies described their attempt to find someone to confirm their suspicions.

Overall, the outcome of reporting was rarely positive for either the child or the teacher and attitudes toward CPS tended to be negative. Respondents complained "nothing was done" and "little was accomplished." Teachers know what abuse is; what they do not know is how CPS defines abuse. These narratives emphasize the importance of educators understanding how CPS makes their decisions and handles the reports. Only by working together and sharing their problems and concerns can the schools and CPS help abused and neglected children.

Head Start and the Child Psychology Course: A Description and Longitudinal Assessment of Students' Volunteer Experiences and Attitudes *David B. Conner*

Paper not available

Head Start Teaching Center: Evaluation of a New Approach to Head Start Staff Development*David A. Caruso, Diane M. Horm-Wingerd, Lynda Dickinson**Presenters: Diane M. Horm-Wingerd, David Caruso, Lynda Dickinson, Julianna Golas*

This paper provides a description of the program and evaluation of the New England Head Start Teaching Center (NEHSTC), 1 of 14 funded nationally to study alternative approaches to Head Start staff development. Head Start Teaching Centers are a national demonstration project created to provide participatory training in all Head Start component areas within the context of an exemplary Head Start program. The NEHSTC is designed to provide intensive training during a three- to five-day period of residence at the Teaching Center.

The formative evaluation conducted during the planning year (1992-93) revealed several impacts on the host program and the staff participating in delivering training. The trainers noted that the process of planning and delivering the training caused them to upgrade their own service delivery and enhance their own skills. Greater staff cohesion and dedication to Head Start were also reported. Staff voiced concerns about being "visited" and evaluated as well as a lack of planning time.

The outcome evaluation used a nonequivalent control-group design with information collected prior to training and one and six months after training. Training and comparison subjects and their supervisors provided information via mailed surveys that was specifically designed to assess knowledge, skills, and competencies in the training content areas.

Analysis of the outcomes for training year one (1993-94) indicates that the NEHSTC training had a significant impact. A 2 (group) X 3 (time) repeated measures analysis of covariance, using the self ratings collected prior to training as the covariate, indicated a significant difference between the groups over time, Wilks' Lambda $F(2, 91) = 8.0, p = .001$. A Tukey Test indicated that significant gains from pretraining to posttraining (one and six months) were reported by trainees but not comparisons. At one month and six months after training, trainees reported significant gains in knowledge, skills, and expertise. The comparisons did not report significant gains from pretraining to one and six months.

A similar pattern was found in the analysis of supervisor ratings. A 2 (group) X 3 (time) repeated-measures analysis of covariance, using the supervisor pretraining ratings as the covariate, indicated a significant difference between the groups over time, Wilks' Lambda $F(2, 78) = 10.1, p = .001$. At both one month and six months after training, supervisors rated the trainees as having significant increases in knowledge, skills, and expertise. No difference between the pretraining and six month ratings was evident for the comparisons.

These results are based on the 51 training and 31 comparison subjects that participated in the evaluation project during training year one. No firm conclusions can be drawn until data from all training years are collected and analyzed. However, the analyses from training year one does indicate that the NEHSTC's training produces significant gains. As compared to similar Head Start employees who did not participate in training, both trainees and their supervisors reported significant gains in trainees' knowledge, skills, and expertise after NEHSTC training.

Professional Development

The Challenge of Inclusion of Head Start and Preschool Teachers in National Performance-Based Assessment: The National Board for Professional Teaching Standards Early Childhood/Generalist Certificate *Julie A. Hirschler*

Presenter: Julie A. Hirschler

The Early Childhood/Generalist certificate from the National Board for Professional Teaching Standards is a new opportunity for teachers of children age three to eight to participate in an individually stimulating professional development activity. For Head Start and other early childhood programs, it is an opportunity to professionalize the field through the recognition of accomplished teachers.

To be considered for National Board certification, teachers participate in a performance assessment consisting of two parts: 1) a teacher portfolio derived from work in the teacher's classroom; and 2) an assessment center consisting of on-demand exercises about early childhood teaching.

A significant feature of this assessment is that the standards on which it was based (the National Board Standards for Early Childhood) were developed, to a great extent, by teachers. Teachers were also key to the development of the assessment exercises themselves, and they serve as assessors or scorers of the assessment.

The Early Childhood /Generalist Standards on which the assessment is based are 1) Understanding Young Children; 2) Promoting Child Development and Learning; 3) Knowledge of Integrated Curriculum; 4) Multiple Teaching Strategies for Meaningful Learning; 5) Assessment; 6) Reflective Practice; 7) Family Partnerships; and 8) Professional Partnerships.

Approximately 50% of the teachers who were candidates for the first Early Childhood assessment were preschool and kindergarten teachers. They were also half of the teachers trained to be scorers for the assessment in 1996, with the remainder being from the primary grades. The first 60 early childhood teachers to be granted National Board certification were announced in late summer 1996. They came from 10 different states.

The Head Start Teaching Center: An Evaluation of an Experimental, Collaborative Training Model for Head Start Teachers and Parent Volunteers

Stephanie Childs, Kathleen Coyle Coolahan, John Fantuzzo

Paper not available

The effectiveness of an experiential, collaborative learning model for teachers and parents in a large, urban Head Start program was examined. This model was compared to an approach based on a more typical outside-consultant training model. The results show promise for the collaborative model.

The Region VII Head Start Mentor/Protégé Program: An Interagency Challenge

Marcia Manter, David Renz, Linda Maslowski

Presenters: Marcia Manter, Linda Maslowski

The Head Start Act of 1994 encourages mentor programs. This concept can be applied fairly readily to teachers mentoring less experienced teachers in the same program. However, directors and managers must look outside of their own agencies for their mentors. The Region VII Mentor/Protege Program was designed to meet this need. The results of the initial year-end formative evaluation are reported in this paper.

A mentor program was established where an experienced director or component specialist from one Head Start agency, the mentor, was paired with a new peer, a protégé, in a different program. The Region VII Head Start Technical Assistance Support Center (TASC), with its partner organizations, developed a program that contacted potential mentors and protégés and offered three interagency mentor/protégé visits, with compensation to the mentor. The goals of the pilot phase of the Regional Mentor/Protégé Program were to 1) speed the process by which new directors and coordinators gain competence; 2) encourage and expand the learning environment within the regional Head Start community; and 3) demonstrate mentoring strategies as a way to provide additional technical assistance to local programs.

An interagency mentor program for Head Start offers special challenges, including distance, differences in authorizing auspices and agency structures, variations in responsibilities of similarly named positions, and variations in program and organization size. While not all the successful relationships included the same characteristics, many of the relationships did exhibit similar features. Among the most notable were 1) both the mentor and protégé believed in the importance of continued learning; 2) the mentor provided useful feedback and could tell the protégé where to seek additional help; 3) the mentor visited the protégé's site at least once; 4) the mentor and the protégé "clicked" and personalities were well matched; 5) the mentor and protégé set firm appointments for calls and visits as well as an agenda for their time together; 6) at the outset, the mentor and protégé discussed expectations and set goals; and 7) the lines of communication were consistently open and clear.

Participants and evaluators suggested increased attention to clear and consistent communications among all stakeholders regarding program purpose and goals, roles, expectations, guidelines, benefits, drawbacks, initial steps, and evaluation. Effective communication between the Head Start funding source and the technical assistance provider will also increase the relationship success. Other suggestions included the following: 1) initial training should be required for mentors and protégés; 2) a careful match should consider distance, program size, responsibilities, work style, and needs; 3) understanding and acceptance of the commitment, time, and energy must occur from both the mentor and the protégé; 4) setting goals, expectations, and areas of professional development by the protégé; 5) the assistance agency should keep in regular contact with the mentors and protégés throughout program; and 6) programs experiencing difficulty or already receiving a great deal of technical assistance may not be conducive to an effective mentor/protégé relationship.

Year One of the Mentor/Protégé Program represents a very successful beginning. The program, as it learns from the evaluative feedback, will continue to grow as an important strategy for Head Start leader development.

Professional Development

Training for Quality: Evaluation of the ECPDN Distance Learning Demonstration

Helene Jennings, Elaine Pierrel Robey, Laura J. Colker, Katherine G. Hoffman, Carolyn S. Dorrell

Presenters: Laura J. Colker, Carolyn S. Dorrell, Helene Jennings, Elaine Pierrel Robey

The Early Childhood Professional Development Network's four-year demonstration of training by satellite was designed to ensure equitable access to high-quality training for all Head Start programs. State-of-the-art distance learning technologies were employed to bring training to staff in rural and remote areas. Live interactive seminars were delivered to teaching teams of teachers, aides, and parents/volunteers via satellite at a wide variety of sites within their local communities (including schools, libraries, public and private facilities). Weekly telephone discussion groups using an audio bridge, led by an early childhood professional, complemented the video presentations. The 35 weeks of training, totaling 120 contact hours, could be applied to the CDA credential, and many participants earned college credit. The project involved over 2,000 participants throughout the United States and territories (Puerto Rico, Virgin Islands, and the Outer Pacific).

Macro International was responsible for the third-party evaluation of this demonstration project. Both formative and summative evaluations were conducted for four cohorts of learners. The evaluation was designed to consider participant demographics, content and format, delivery, and outcomes. Methodologies included various questionnaires (including quick post-seminar feedback via fax); telephone interviews; monitoring of telephone discussion groups; case studies; observations at training sites and Head Start centers (including pre/post classroom assessments); and a video-based assessment to measure knowledge and application.

Ratings of each seminar in each phase gave program designers feedback for seminar improvements. Appraisals of the program formats prompted increased attention to guided observations. Additionally, the importance of the telephone discussions in creating a community of learners was documented. The value of training as a team and providing interactivity in instruction served to reinforce the original program design.

The Kolb Learning Style Inventory was administered to all cohorts. About 80% of participants were in the two learning profiles that prefer concrete experiences, though they were equally split between the observational versus hands-on approach (Diverger=41.9%, Accommodator=36.7%).

Participant reactions were measured with the following results: 1) 77% reported that the use of technology "helped me to understand better" than traditional classroom instruction; 2) 54% reported that technology seemed "very personal and interactive"; 3) 74% stated that the training "provided more new ideas" than other training; and 4) 94% of those completing the program would take another distance learning course. Pre- and posttraining observations using instruments from Arnett and Abbott-Shim in nine diverse programs found these classroom changes: room arrangement (enriching the learning environment); child choice (fostering a child's independent learning); affective (improving teacher-child interactions); activities (increasing the variety of learning activities); and positive guidance (managing children's behavior more effectively).

A video-based assessment was developed by Colker and Jennings that presented video scenes from Head Start classrooms and posed questions to measure knowledge gains and application of principles. It was administered on air with successful results in terms of comfort level with the assessment and scores achieved by the participants.

Effects of Training for Infant and Toddler Caregivers in Head Start and Day Care Programs

Jane King Teleki, Charles W. Snow, Betsy T. Thigpen

Presenters: Jane King Teleki, Betsy T. Thigpen

Research was conducted to see if subjects differed in knowledge of child care and development and in caregiving behaviors before and after training that included both classroom instruction and laboratory experiences. Subjects were 31 adults who provided center-based care for infants and toddlers. Ages ranged from 20 to 59 years ($m=34.03$, $sd=10.21$). They were almost evenly divided with regard to place of employment (Head Start 48.4%, Day Care 51.6%) and race (African American 45.2%, White 51.6%, other 3.2%).

Responses to a child care and development Knowledge Test were obtained from each caregiver before and after participation in a training program designed specifically for infant and toddler caregivers. Also, participants were observed working with infants and toddlers in their regular classrooms before and after training. Information about caregiving behaviors was obtained using the Infant/Toddler Environment Rating Scale (ITERS) and the Caregiver Interaction Scale (CIS). Training consisted of 22 hours of theory-based instruction and 22 hours of "observe then do" guided participation in a laboratory classroom setting.

For the total sample, significant differences between pretest and posttest scores were found for the Knowledge Test, total ITERS, all seven ITERS subscales except Personal Care Routines, and all CIS factors except Permissiveness. All significant differences were in the direction of improved quality of care for infants and toddlers. Examination of measures obtained before training showed significant differences between Head Start and Day Care scores for the total ITERS and four ITERS subscales: Furnishings and Display for Children, Personal Care Routines, Program Structure, and Adult Needs. For all four, Head Start means were higher.

After training, Head Start and Day Care scores did not differ significantly for total ITERS nor Personal Care Routines. Significant differences were found between the two groups for three ITERS subscales: Furnishings and Display for Children, Program Structure, and Adult Needs. In all cases, Head Start means were higher. The CIS Detachment factor was significantly different: the Head Start mean was lower.

Differences in before and after scores for Head Start and Day Care as separate groups were analyzed. For Head Start, significant differences were found in pretest and posttest scores for the Knowledge Test and two ITERS subscales, Interaction and Adult Needs; scores after training were higher. The CIS factors of Positive Interaction, Punitiveness, and Detachment differed significantly before and after training. After training, Positive Interaction scores were higher, and Punitiveness and Detachment scores were lower.

For Day Care, significant differences in before and after scores were found for the Knowledge Test, the total ITERS, and all seven ITERS subscales; scores after training were higher. Also, the CIS Positive Interaction factor differed significantly; it was higher after training.

This study has implications for the public policy issue of training requirements for caregivers in early Head Start and Day Care programs. Findings are consistent with others in showing that even a brief training program can have important influences on caregivers and the quality of child care they provide to infants and toddlers.

Social and Academic Competence

Social Competence over Time in Relation to the Presence of a Friend for Preschool Children

Muriel R. Azria, Lisa Krzysik, Lisa Wakeem-Caye

Presenter: Muriel R. Azria

The purpose of this study was to examine the effects of friendship status over a one-year period on social competence in a lower income population attending Head Start. The social competence of children who moved from one year to the next, with or without a friend, and of children who moved from one year to the next with reciprocated and nonreciprocated friends was examined. To address this issue, preschool children in five different Head Start centers ($N=512$) were studied ($N=244$ for year 1; $N=268$ for year 2; 115 longitudinal). Information from the second year was used to identify the following three groups of children: those with a friend, those without a friend, and children attending Head Start for one versus two years. Information from the first year was used to differentiate between reciprocal and nonreciprocal friendships. Two hundred forty-four children were assessed during the first year, while 115 (57 male and 58 female) were measured in both their first and second years of Head Start. Competence assessments for both years included sociometric measures, observational assessments that were organized using Q-sort techniques, and a measure of visual attention received from peers.

Three hypotheses were tested. Firstly, it was hypothesized that longitudinal children in their first year would not be characterized as significantly different from other children in the first year. If children who attended Head Start for both years were characterized as more socially competent than children observed in their first Head Start year at age four, then it would suggest that experience in Head Start is associated with an increase in social competence. Analyses testing for the effects of experience in Head Start supported this hypothesis and demonstrated that children who attended Head Start for two years were judged to be more socially competent than those who entered Head Start at age four.

Secondly, for the longitudinal cases only, the possible effects of friendships were evaluated in a series of analyses of variance. Effects of all friendships as supports for social competence were examined in a comparison of social competence scores in Year Two for children who moved across years with friends and those who moved across years without any friends. Analysis of variance did not demonstrate a significant difference between children who moved over time with friends and children who moved over time without friends; however, a Gender X Friendship status interaction was found. Girls who moved over time with a friend fared better than girls who moved over time without a friend. This trend was not found for the boys, however; boys who moved with a friend were not more advantaged than boys who moved over time without a friend.

Thirdly, a comparison of three longitudinal subgroups was conducted (having a reciprocated friend, a nonreciprocated friend, or no friend). To the extent that participating in reciprocated friendships was a sign of social competence, it was anticipated that children moving with a reciprocated friend would be advantaged regarding social competence in comparison to children in the other two groups. The results suggested that girls who moved over time with a reciprocated friend demonstrated higher social competence scores than girls who moved over time with a nonreciprocated friend and girls who moved with no friends. This finding was not observed for the boys of our sample. Boys who moved over time without friends fared better than boys with reciprocated friends and boys with nonreciprocated friends.

The Role of Motivation in the Later Competence Development of Early Enriched Children from Different Backgrounds

William Fowler, Karen Ogston, Gloria Roberts-Fiati, Amy Swenson

Presenter: Karen Ogston

Seventy-one infants received language enrichment activities via interactive play and care routines through home interventions in three dissertations (randomized controls) and case studies in families from diverse ethnic/racial and educational backgrounds. One study, Ogston, also provided exercise activities to one subgroup, and another, Roberts-Fiati, added general cognitive enrichment to her Afro-Caribbean infants, along with limited parental education. Every infant made substantial language program gains beyond norms (5+ words by 7 to 11 months and phrases by 10-17 months, compared to norms of 13 and 21 months). Dissertation language program groups generally advanced significantly over controls in language and cognitive skills. Ogston's motor program group unexpectedly also advanced significantly over controls in language and cognitive skills (as well as motor skills), the unanticipated effect of parents' extensive use of language to mediate the gross motor training. Ogston's controls were also found to have made tremendous language gains by age 30 months, as a result of furnishing control parents with both written and oral guidance in language enrichment at program termination at 16 months.

At follow-up in adolescence, 68% of the children from college-educated families and 31% from less-educated families were gifted. (Ns of 40 and 16 located) Additionally, 70-93% of the former group and 44-81% in the latter have attained superior competencies and achievement in a variety of domains, above all verbally but also in math, science, the arts, sports, and social skills. None of the 10 controls for the 11 Afro-Caribbean participants have been gifted, and only 20-30% are highly competent in any domain. Motivational development is also outstanding: 93% of children with parent(s) with college background and 81% of students from less-educated families displayed some form of high intellectual independence and self-directed motivation. Additionally, 63% of participants from college-educated families and 31% of those from less-educated families have been motivated to demonstrate intellectual leadership. Only 20% of students from the Afro-Caribbean control families were intellectually motivated, and none displayed intellectual leadership.

Formal ratings on motivation among interest areas generally were higher in verbal areas, including 55-65% in creative writing and 82% in reading among participants with college-educated parents and 88% for reading among those with less-educated parents. Especially interesting are the 50% of the latter participants with strong interests in math and science, compared to the latter of 59-64% in science and 18-35% in math. Ratings on initiative, autonomy, frequency of participation, persistence, cooperation, and other motivational indices generally ranged from about 50-80+% in participants from families at both educational levels. Apparently, the combined cognitive/social interaction-oriented early language enrichment generated exceptional competencies and motivation that enabled participants to respond to later opportunities and actively pursue cognitive development in diverse areas.

Is Grade Retention an Appropriate Academic Intervention? Longitudinal Data Provide Further Insights

Shane R. Jimerson, Michelle R. Schuder

Presenters: Shane R. Jimerson, Michelle R. Schuder

"Being retained" refers to the nonpromotion of a student to the following grade at the completion of a school year. Each year, nearly 2.5 million children are held back in the United States. Our nation spends over 10 billion dollars annually to re-educate these children (\$6,000 per pupil). Given these staggering figures, the policy of retention warrants scrutiny.

A recently published text on early grade retention declares that the efficacy of retention in the primary grades remains unclear. Many previous studies have examined whether grade retention is an effective intervention to remediate poor school performance. Although multiple studies and reviews suggest that retention is an ineffective and potentially harmful intervention, many prior studies are acknowledged to be methodologically flawed or biased in design. A comprehensive examination of early grade retention must include longitudinal data that considers multiple aspects of one's educational experience (e.g., family, achievement, adjustment).

In the current study, the effectiveness of early grade retention as a means to facilitate academic performance and school adjustment is investigated using prospective longitudinal data collected from birth through age 19. Data on high-risk children were examined to identify the characteristics of children retained in early elementary school and to assess later achievement and adjustment in the elementary years through high school.

This study examined the efficacy of early grade retention (K-3) using data from a prospective longitudinal study of high-risk, ethnically varied children. The characteristics of children retained in early elementary school and later achievement and adjustment were analyzed through age 19. The retained group (N=29) was compared to a group of nonretained children (N=50) comparable on achievement and IQ. A control group (N=100) was also examined to verify that the measures were able to discriminate differences between students (these results are not reported herein). Retained students were more likely to be males who demonstrated poorer adjustment. The parents of comparison children were higher on IQ and were more involved with the school than parents of the retained children. Controlling for initial levels of achievement and adjustment, little evidence was found supporting retention as an intervention for improving educational outcomes. The retained students displayed a temporary advantage on mathematics achievement during the subsequent grade that disappeared as the students were presented with new material during the elementary years. During the sixth grade the retained students displayed significantly lower emotional health. Age 16 year analyses suggest no differences in achievement or adjustment. At age 19, the overall high school academic adjustment was significantly poorer for retained students. In addition, these analyses illustrate that retained students were more likely to withdraw from a traditional program and less likely to receive a diploma. Education professionals and policymakers are encouraged to re-examine current retention practices within their own school, district, or state in light of these longitudinal data.

The Relationship of Maternal Employment and Attributes to Kindergarten Children's Adjustment *Julia A. W. Wallace*

Presenter: Julia A. W. Wallace

The relationship between kindergarten children's dependency, adjustment, and social competence (i.e., prosocial behaviors, antisocial behaviors, academic competence, and psychosomatic behaviors) and maternal employment and attributes (i.e., the importance of a career and maternal role to the mother, and her guilt or sadness at being separated from her child) was explored. The sample was 80 kindergarten-aged children who were part of a previous longitudinal study that began at birth. Objectives of this study were to 1) understand the influence of maternal employment and related factors on adaptive and dependency behaviors in kindergarten children; and 2) examine these behaviors across time using significance-tested cross-lagged panel correlations for the analysis.

Children were rated by their mothers and teachers on 13 child behaviors. Of those 26 ratings, only 5 were significantly correlated with maternal employment per se. Employed mothers perceived their children to be more hyperactive/distractible, more dependent, less academically competent, and less independent. Teachers rated children of employed mothers to be less altruistic. Nonmaternal care associated with employed mothers was related to teachers' perception of increased expressive talent and antisocial hostility in kindergarten children. Mothers employed full time perceived their daughters to have significantly more depression and somatic anxiety than sons, and sons were rated as more dependent than daughters. With the exception of altruism, teachers did not significantly rate children differently based on their mothers' employment status.

Multiple Linear Regression Analyses revealed that maternal employment and attributes were significant predictors of seven mother-rated and two teacher-rated child behaviors. Cross-Lagged Panel Correlation Analyses of data from the current study and the matching data collected three years earlier were significance-tested using a modified Z-score. Across time, mothers who valued their career highly when the child was in preschool rated their children high on altruism at kindergarten age. Mothers who perceived their preschool children to be highly dependent had higher levels of maternal separation anxiety when the child was kindergarten-aged.

The results suggest that employed mothers perceive their children's social competence and dependency differently than nonemployed mothers. These behaviors are those that would be important to a mother stressed by balancing home and work responsibilities. The cross-lagged panels suggest that children may influence mothers and mothers may influence children.

Direct and Indirect Pathways from SES to Academic Achievement: Implications for Intervention

Emma K. Adam, Amy Susman-Stillman

Presenters: Emma K. Adam, Amy Susman-Stillman

The question of how individual components of early socioeconomic status (household education, occupation, and monetary stress) are related to later academic achievement during two time periods was investigated in this 16-year longitudinal study. In particular, we asked: Are the effects of household education, occupation, and monetary stress on children's academic achievement mediated by the quality of their home environment? Are these processes different during the preschool years as compared to the elementary/high school years? Data were drawn from the Parent-Child Project, an ongoing longitudinal investigation of children at risk for developmental problems. Mothers participating in the study were primarily White (80%), relatively young (average age during pregnancy was 20.52 years), and of relatively low educational status (40% non-high school graduates). Data for 116 mothers were available for these analyses, gathered across a 16-year time span. Data on household education, occupation, and monetary stress (our income variable) were available at multiple time points, and were composited to provide average measures for each of two time periods: the preschool period and the elementary/high school period. Our mediating variable, Caldwell HOME environment, was also available during these two time periods. Educational achievement at the first grade and at 16 years of age (measured by the Peabody Individual Achievement Test and the Woodcock-Johnson Tests of Achievement, respectively) were our outcome variables. The contribution of Maternal IQ to SES, HOME environment, and achievement variables was controlled in our analyses. Path analytic techniques (using LISREL 7.0) were employed.

During the preschool period, a consistent pattern of results emerged regarding the effects of SES on academic achievement: household education, household occupation, and monetary stress all had significant effects on academic achievement through their effects on the quality of the home environment. Direct pathways between SES variables and grade one achievement were not significant when the quality of the home environment was taken into account, nor were there direct effects of maternal IQ on academic achievement. During the elementary/high-school period, however, only household education continued to exert effects on adolescent achievement once the strong effect of prior achievement was taken into account. In contrast to the earlier years, this effect on achievement was direct, rather than mediated through the quality of the home environment. Because SES effects on achievement are most evident in the preschool rather than the later school years, SES-related interventions may be most beneficial for children's educational outcomes if they occur prior to school entry. The achievement level that children establish by grade one tends to persist over time, regardless of later SES changes. Because the home environment appears to mediate early SES effects, policies and interventions could be targeted at improving the quality of the home environment as well as at the SES component itself. Household education may be the most important variable to target during the later school years, since it was the only SES component that had significant additional contributions to academic achievement beyond the preschool years.

Enhancing Young Children's Social Competence: Enhance!/Social Competence Program (ESCP)—A Field-Developed Program for Children, Teachers, and Parents

Halina Marshall, Mary Temple, Guillermo Montes, Rebecca Russell

Presenters: Halina Marshall, Mary Temple, Guillermo Montes, Rebecca Russell

A young child's balanced psychological development and preparation for school is best achieved when his or her needs are met in the context of family, school, and community. The development of a strong social-emotional foundation facilitates a child's ability to interact successfully with and benefit from the environment. Poor social-emotional skills affect a child's level of social competence and may negatively impact growth in other developmental domains. A child who is unable to develop a trusting relationship with a teacher, or at the very least to follow directions, may miss many valuable learning opportunities. Similarly, a child who consistently displays socially inappropriate behavior diminishes opportunities to develop skills and relationships that are typically developed in the classroom setting. Consequently, delays in the acquisition of social competencies at a young age can have a lasting impact on children's school readiness and adjustment.

The Enhance!/Social Competence Program (ESCP) is designed to enhance preschool and kindergarten children's social competencies and problem-solving skills. It consists of a sequence of 41 activities in three units (Language Development, Feelings Identification, Social Thinking, and Problem Solving). Although designed to blend into a classroom routine, these activities can be easily adapted for use at home.

In the early stages of ESCP development, efforts were made to address the needs of urban, low-SES children. Parents and early childhood teachers who piloted ESCP provided valuable insight into the appropriateness of the activities. These field tests helped ESCP clearly target developmentally appropriate concepts that should enhance children's social problem-solving skills, social competence, and general school readiness.

Evaluation of ESCP was conducted in eight preschool classes during 1994-95. The children from four classes receiving ESCP training were compared to children who used no systematic social problem-solving program. Changes in language, social problem-solving, and pre-academic skills were measured using pre-post individual assessments of all involved children. Rating scales and questionnaires measuring social-emotional and adaptive skills were also completed by the teachers. Preschool children improved in cognitive and language areas above developmental norms and in general school adjustment skills. Children exposed to ESCP were more assertive, tolerated frustration better, and had better task orientation.

Based on these results, new directions and initiatives are being planned for ESCP. It should be evaluated on both urban and rural children. Prevention and intervention programs need to support the whole child across multiple settings. Understandably, parents are viewed as critical agents in the development of a child's social competence. Ideas to assist teachers and parents on how to collaborate, share information, and facilitate the use of ESCP, in both school and at home, are being generated. Furthermore, the benefits of using ESCP as a multiyear program that ranges from preschool through kindergarten, and possibly the primary years, are being explored. The children who participated in ESCP in preschool, but who came from disadvantaged home environments or who did not previously have ESCP, would also benefit from the program at the kindergarten level. Finally, the questions of the appropriate directions for this program to take to optimize the young children's social competence, and the instruments to be used to adequately assess these gains, need to be investigated.

Social and Academic Competence

Relations between Emotional Self-Regulation and Social Competence among Head Start Preschoolers

C. Cybele Raver, Erika Blackburn, Mary Bancroft, Nancy G. Torp

Presenters: C. Cybele Raver, Erika Blackburn, Mary Bancroft, Nancy G. Torp

The relationship between children's strategies to regulate their emotions and social competence was examined for 51 Head Start preschoolers in two counties located in upstate NY. Children who engaged in more effective strategy use during a self-regulation task were independently viewed by their peers as more competent than were children who were less effective at self-regulation. Children who used effective regulatory strategies were also viewed as less externalizing by teachers in one county, but not in the other. Findings may prove useful to interventions designed to support the healthy social development of low-income children.

Linkages between Children's Social and Academic Performance: Implications for Intervention and Prevention

Mara Welsh, Ross Parke, Robin O'Neill, Alicia Gilbert, Rebecca Vasquez, Tasha Howe

Paper not available

The established links between early social acceptance by peers and later social and academic adjustment (Parker and Asher, 1987) indicate the need to identify and target children for intervention and prevention. Sociometric and academic methods are used within a longitudinal study in order to further clarify this relationship.

Homelessness and Exposure to Community Violence: Child and Maternal Adjustment among Urban Head Start Families

Cheryl C. Holland, Sally Koblinsky, Raymond Lorion, Elaine Anderson

Presenter: Cheryl C. Holland

Homelessness and community violence are major social and public health problems that may not only have direct effects on children, but also may impede parental ability to cope and protect their children. Head Start policymakers recognize these increasing problems and stress that research is urgently needed to develop strategies for buffering families. However, there has been little investigation of the prevalence and cumulative psychosocial effects of homelessness and community violence, particularly among preschool populations. Therefore, this study explored the independent and additive relationship between homelessness and exposure to community violence in predicting 1) maternal depression; 2) parenting effectiveness (nurturance, responsiveness, and consistency); and 3) child behavior problems. It was hypothesized that homelessness and community violence exposure would be associated with compromised maternal and child functioning. It was further hypothesized that maternal functioning would moderate the relationship between these ecological stressors and children's adjustment.

Participants were 48 homeless and 56 housed mothers and their Head Start children in the Baltimore-Washington, D.C. area. Approximately 84% of the mothers were African American, 14% were White, and 2% were Latino. Homeless mothers resided in transitional shelters, emergency shelters, or doubled-up with family or friends. Mothers completed a two-hour interview including measures of community violence and maternal and child functioning. They reported substantial victimization and witnessing of violence and reported that community violence was one of their greatest worries, second only to personal finances. Two thirds of the mothers heard shooting twice per week. Approximately 30% had witnessed or known a victim of a violent death within the last year. Homeless mothers reported significantly more exposure to violence than housed mothers ($p < .05$). Multiple regression analyses revealed that direct violence victimization was significantly associated with higher maternal depression and less consistent parenting.

The relationship between violence exposure and parenting consistency was stronger among housed than homeless mothers. Mother's age was significantly predictive of parenting effectiveness, beyond the influence of homelessness or violence. Older mothers reported more effective parenting behaviors. When predicting a global measure of child behavior problems, parenting effectiveness and the number of adults in the home were more predictive than homelessness or violence. More effective parenting and multiple caregivers in the home were associated with fewer child behavior problems. However, when predicting child anxiety/depression, there was a significant relationship between violence and higher levels of child anxiety/depression among families where mothers were more depressed. Findings suggest that regardless of housing status or level of violence exposure, Head Start programs and effective parenting buffer children against the impact of poverty and violence. Implications include the need for Head Start to provide outreach to depressed mothers in violent neighborhoods who may be less able to buffer children from violence than nondepressed mothers. Particularly in violent, chaotic neighborhoods, Head Start parents must be assisted in providing structure and stability for children. Parent education programs must be expanded in high-risk communities, particularly targeting young mothers and providing developmentally appropriate parenting strategies to address these stressors.

Stressors: Homelessness

A Descriptive Evaluation of a Tutor Program for Children Experiencing Homelessness

Arturo Sesma, Jr., Rekhet Si-Asar, Christine M. Hurley

Presenters: Christine M. Hurley, Arturo Sesma, Jr.

The goals of this study are threefold: 1) provide descriptions of site-based intervention programs for children experiencing homelessness; 2) describe characteristics of children receiving tutoring services versus children not receiving services; and 3) compare these two groups of children on attendance rates, behavior in school, teacher impressions of academic potential and academic progress, and teacher-reported relationship quality with the student. Ninety-eight 8- to 10-year-old African-American children (45 girls) and their mothers were initially assessed at a homeless shelter in the fall of 1995 on demographic information, child and mother school history, behavior problems (as reported by mother) and achievement (via the Wechsler Individual Achievement Test-Screener).

Elevated group means on behavior problems and depressed means on achievement indicated that this sample of children experiencing homelessness are at significant risk for later developmental problems. Fifty-six children from the original sample remained in Minneapolis through the school year. Of these, 15 children received tutoring services. For data analysis purposes, we compared 11 tutored children with 22 comparison children. There were no differences in these two groups on demographics, school history, behavior, or achievement. The programs, which were targeted in 14 of the 63 public elementary schools, were individually designed by the tutor/advocates. As such, there was great variation in types of services offered, how these services were delivered, and the frequency of contact. Despite these variations, tutor/advocates uniformly felt that the most important functions of the programs were to facilitate a connection between the child and the school, as well as to establish a relationship with the child beyond a tutor-student relationship. As such, our evaluation strategy was to assess "process" variables that may indirectly lead to better achievement. (Achievement variables, such as CAT scores and spring grades, were not yet processed at the time of writing.) These included attendance, behavioral conduct in the classroom, teacher impressions of academic achievement and academic progress over the past month, and teacher ratings of the levels of conflict, closeness, and dependency in the student-teacher relationship, as well as an overall student-teacher relationship score, measured at the end of the spring semester.

We found that teachers perceived closer relationships with students in programs versus those who were not, even after controlling for prior achievement and prior problem behaviors. There are three main conclusions from this study. First, this study corroborates past research on the high-risk status of children experiencing homelessness on a number of adaptational indicators (e.g., achievement and behavior problems). Second, programs should include a comprehensive battery of services, beyond academic help, for children experiencing homelessness. "Process" variables that may lead to better achievement, such as behavior management and relationship skills, should also be emphasized. It may be important to establish a close relationship with the child, thus helping him/her feel a greater sense of connection with the school. Finally, programs should be tailored to the needs of the student/neighborhood/community populations they are serving. This can be accomplished by involving the parents in the planning and design of programs for their children. In this way, interventions aimed at mitigating the effects of homelessness and extreme poverty are sensitive to the needs of the populations they are seeking to serve.

Evaluating a Model of Head Start and Other Concurrent Interventions in Poverty and Homelessness *Brad Richardson, Miriam Landsman*

Presenters: Brad Richardson, Miriam Landsman

Data from nearly 200 participants in two related programs operated by HACAP (Hawkeye Area Community Action Program of Linn County, Iowa) are used to evaluate the process and outcomes associated with interventions in homelessness and enrollment and retention of homeless children in Head Start programs. From the Homeless Head Start Project (HHSP), family-level data are gathered through the use of the quarterly Homeless Head Start Tracking Guide (HHTG), and services provided through the program are reported quarterly on the Service Tracking Guide (STG). A 100% sample of participants in both projects was selected. Feedback to the program through consumer satisfaction questionnaires and interviews with staff of provider agencies, which make up the Supportive Services Team, was also provided by the evaluation.

From the Transitional Housing Project (THP) we track risk factors that include childhood experience, household, demographic, employment, education, economic, violence and victimization, health issues, crime and criminal history, stressful life events, and other information about the children (e.g., abuse and neglect, school achievement). A Transitional Housing Follow-Up report is completed by participants six months to one year following exit from the program on present housing status, employment, education, economic status, family changes, and an overall narrative written by the participants.

The evaluation data reveal the following characteristics about the families: 1) 51% were raised by one parent; 2) 35% moved a lot growing up; 3) 46% lived out of home; 4) 42% felt neglected as child; 5) 75% believed their family did best they could; 6) 41% were beaten hard as child; 7) 31% experienced sex abuse by age 14; 8) 55% experienced domestic violence as adult; 9) 67% lived with substance abuse; 10) 33% had a chronic medical problem; 11) 24% should cut down drinking; 12) 18% were annoyed by criticism of themselves; 13) 24% felt guilty about drinking; 14) 11% had a drink/drug first thing; and 15) 24% felt that they had a substance abuse problem.

"Negative relationship with spouse/boyfriend" and "poor motivation" were cited most often as significant barriers, with "lack of social skills," "psychological problems," and "low salaries of available jobs" mentioned as contributing factors in impeding client progress.

For homeless children who have been enrolled in Head Start, the attendance rate has been stabilized at 85% since the inception of the HHSP. In addition to meeting the project's attendance goal, nearly all children in the project had been retained in their original Head Start classrooms.

At the time participants exited the program, the median family income had increased from \$426 per month at program entry to \$820 per month. Even those who were discharged from the program for cause showed substantial increases in income. For those who were discharged the median income increased to \$620 per month.

Following are some typical responses when we asked participants, "What are two things that have changed in your family because of the program(s)?" "My son really enjoys going to Head Start and looks forward to it." "It has really increased his self-esteem." "It has helped me with my budget and finances." "The school enhancement has helped my son deal with improving grades." "My self esteem has come up a lot because I don't have to worry about a place to live." "We have a home!" "I probably couldn't have survived." "My son is potty trained!"

Stressors: Homelessness

A Pilot Mentoring Program: Addressing the Social Isolation and Academic Failures of Homeless Children *Linda J. Anooshian, Zan Payne*

Presenters: Linda J. Anooshian, Zan Payne

The lives of homeless children are characterized by social isolation and poor relationships. We argue that, by using the proper infrastructure support and targeting the elementary years, mentoring programs offer promise in providing protective factors for homeless children whose lives are otherwise full of risk factors. The rationale for mentoring programs is largely that homeless children experience widespread social isolation and low-quality social relationships apparent in poor parent-child relationships, sibling conflict, negative labeling and stereotyping in schools, poor social skills in interacting with peers, and anxiety and distrust in social contexts. Overall, we argue that extensive child development research addressing family and social relationships can help us understand the sources of well-documented negative outcomes for homeless children. In addressing intervention, it will be imperative that we address ways of making sure that homeless children grow up with the healthy social relationships that child development experts have come to recognize as essential to normal development.

The consensus of research over the past decade indicates that one positive mentoring relationship with a caring adult can make a difference in the life of an at-risk child. Based on our pilot program, we offer guidelines for mentoring programs for homeless children. As noted by Freedman, the current popularity of mentoring is associated with increasing failures, usually of mentor programs without a sufficient supportive infrastructure. Our program—and our recommended approach—involves collaboration with an organization with a good track record with mentoring and a strong infrastructure. As also noted by Freedman, a number of mentoring programs, in addressing their failures, have recognized that adolescence may be too late to intervene for many at-risk children. In contrast to most mentoring programs focused on the teenage years, we recommend that mentoring programs for homeless children focus on younger children.

Nevertheless, important questions remain. First, can mentoring relationships have positive effects for children from such transient families? With the best of efforts to maintain contact, many mentors will lose track of their matches when families move. Even short-term mentoring should provide a helpful and supportive relationship for homeless children, but this is an empirical hypothesis that has yet to be evaluated. Second, have homeless children already experienced so much social isolation and rejection that they are unable to establish healthy relationships with adult mentors? Even if we start mentoring programs well before the teenage years, the question calls for empirical research examining the effectiveness of mentoring for homeless children. To address these questions, we need well-designed mentoring programs for homeless children combined with systematic assessments of their effectiveness. In meeting this need, we hope to extend our pilot model for mentoring to other sites; participation would require a commitment to collecting data on mentors and their mentees and families, as well as data designed to evaluate the effectiveness of the mentoring efforts.

Social Isolation of Homeless Children: Seeds of Academic Failure

Linda J. Anooshian, Zan Payne

Presenters: Linda J. Anooshian, Zan Payne

This research addresses ways in which social isolation mediates or accounts for the strong associations between homelessness and pervasive negative outcomes for homeless children, forming the "seeds" of academic failure and intergenerational homelessness. Diverse measures were obtained to capture the pervasiveness of the social isolation or lack of high-quality social relationships experienced by homeless families and children. In structured interviews with designated "target" children (6-12 years of age), their siblings (3-17 years of age) and their mothers, we obtained measures reflecting four general sources of social isolation: the mother-child relationship, the sibling relationship, peer relations, and other sources of social isolation outside the family. Yet other measures reflected two general categories of hypothesized consequences of social isolation: measures of level of functioning (depression, intellectual ability) and cognitive vulnerability (dysfunctional cognitions reflected in poor self-esteem, negative beliefs and expectations). For target children, additional measures were obtained from teachers and school records.

Data analyses revealed associations between longevity of homelessness and level of functioning, as well as ways in which social isolation variables mediate connections between homelessness and negative outcomes. Research findings revealed 1) specific problems with the friendships and support networks of homeless mothers; 2) quality of parenting as influenced by the specific help that mothers received with parenting; 3) self-esteem as an important component of the "cognitive vulnerabilities" of homeless children; 4) aggression and withdrawal as different risk factors for peer relationships; and 5) specific behavioral consequences of witnessing violence for homeless children.

Difficulties and cautions in interpreting the research findings were also discussed, including 1) the need to avoid value judgments and cultural bias (e.g., in designating high-quality parenting); 2) difficulties in avoiding cause-effect inferences (e.g., in failing to recognize how children shape parents); and 3) problems with self-report measures. The extent of disagreement between reports of mothers and children was reliably correlated with measures of functioning (for both mothers and children). Despite interpretational difficulties, the research findings make a significant contribution to understanding the long-term adverse consequences of homelessness for children. Based on our findings, we recommend mentoring as a cost-effective approach to providing homeless children with supportive social relationships. From a policy perspective, our results reinforce that we cannot afford not to intervene; as a society, we cannot afford the high fiscal and humanitarian costs of academic failures and intergenerational homelessness.

Stressors: Homelessness

Foster Care and Homelessness: Breaking the Cycle of Family Dissolution

Ralph deCosta Nunez

Presenter: Unable to attend

A detailed study comparing homeless heads of household who were in foster care as children to those who were not found a significant correlation between foster care histories and a heightened risk of both homelessness and family breakups. Those adults who grew up in foster care became dependent on welfare at an earlier age, and had less work experience and higher incidences of substance abuse, domestic violence, and mental illness than the typical homeless adult. Even more dramatically, these parents were more than twice as likely as the overall homeless population to have at least one of their children in foster care. The probability is high that their children will repeat this cycle of foster care and homelessness.

With the link between foster care and homelessness becoming ever more apparent, the need for preventive services geared toward breaking this destructive cycle is more pressing than ever. The combination of research and the provision of services based on the connection between foster care and homelessness offers the opportunity to effectively address the needs of families at risk of dissolution. Out of this effort arises an innovative family support and preservation program that gives both children and parents the support that they need to stay together.

The Family Crisis Nursery Program provides temporary, emergency child care with no legal separation when a family emergency or parental stress creates the potential for child abuse or neglect. This respite care, offered free of cost to any New York City family, helps prevent child abuse and neglect and avert unnecessary foster care placements and family breakup. In tandem with its temporary, emergency child care, the Family Crisis Nursery Program provides parents with ongoing support to help them resolve the underlying issues that prompted their use of the Crisis Nursery. Through a unique aftercare component, this support continues long after a family has used the Nursery's child care services. Aftercare workers are essential in helping parents stabilize their families so that future emergencies do not put children at risk of abuse, neglect or long-term separation from their parents.

Both Crisis Nurseries are located in service-rich transitional housing facilities. This location allows the program to be closely integrated into the intensive continuum of on-site family support and educational services. The comprehensive array of programming is designed to help families break the cycle of poverty and homelessness and move toward independent living.

The Crisis Nursery program has shown a great degree of success in this context, but its applicability is not limited to the transitional housing environment. Such a coordinated approach could easily be implemented at community centers and schools throughout the country, offering families at risk of breaking up the support they need to stay together and grow strong. The dramatically enhanced effectiveness of this combined family preservation and support model has the potential to positively impact the lives of families and children nationwide.

Social Support Networks: A Comparison of Permanently Housed and Homeless Head Start Mothers Living in Four Housing Situations

Bethany L. Letiecq, Elaine A. Anderson, Sally A. Koblinsky

Presenters: Bethany L. Letiecq, Elaine A. Anderson, Sally A. Koblinsky

Families with children have become one of the fastest growing segments of the homeless population. Although homeless families are often treated as a homogenous group, they frequently experience different housing situations that may influence the nature and extent of their social supports. Housing situations in which homeless families reside include emergency shelters, transitional housing, and doubled-up arrangements. Emergency shelters, which typically provide one night to four weeks of shelter, often lack support services (e.g., child care) and do not provide the stability most parents need to move toward self-sufficiency. Transitional housing programs, which provide families with apartments for up to two years, may also offer job training, parenting classes, substance-abuse programs, and assistance in locating permanent housing. A third type of living arrangement occurs when families live with other relatives or friends as a last resort. Referred to as "doubling-up," this living arrangement is often stressful and temporary.

Previous research has examined the social support networks of homeless parents, but few studies have investigated social support among homeless Head Start parents. Moreover, existing studies have not differentiated between the various temporary housing arrangements encountered by homeless families. Therefore, this study compared the social supports of homeless mothers living in emergency shelters, transitional shelters, and doubled-up arrangements to those of permanently housed mothers.

The study was part of a larger DHHS-funded project examining maternal and child functioning in homeless and housed Head Start families. Participants included 92 homeless and 115 low-income housed mothers of preschool children who were attending a Head Start program in the Washington, D.C./Baltimore area. The majority of mothers sampled were African American (92.2% housed and 81.5% homeless) and single parents (82.6% housed and 95.7% homeless). Of the homeless mothers, 33.7% resided in emergency shelters, 47.8% lived in transitional housing, and 18.5% were temporarily doubled-up.

This study utilized three measures of social support, including measures of social embeddedness, perceived availability, and enacted support. Results revealed emergency and transitional sheltered mothers saw or talked to significantly fewer people weekly than their housed counterparts. Homeless mothers residing in emergency shelters also perceived significantly fewer people available to care for their children if needed, and both emergency and transitional sheltered mothers felt they had significantly fewer people available to help them in times of need than housed mothers. Further, homeless mothers received significantly less enacted support than housed mothers. Specifically, emergency and transitional sheltered mothers received significantly less help from their family members, and doubled-up mothers received significantly less support from professional helpers, such as social workers and Head Start teachers, than did housed mothers.

The current findings have important implications for Head Start staff and family service providers. Because emergency and transitional sheltered families exhibited significantly less familial support than did their housed counterparts, efforts should be made to help families obtain shelter within their communities and maintain contact with family members (except when these relationships threaten to harm family members). Head Start staff must also make efforts to identify doubled-up families who may be lacking professional supports.

Stressors: Poverty and Its Ramifications

Foster Infants' History and the Evolving Attachment Relationships

Kathlyn Chase Stovall, Mary Dozier

Presenters: Kathlyn Chase Stovall, Mary Dozier

This study examines the evolving attachment relationships between infants and their foster parents. In the preliminary phase of this work, we examined the daily diaries kept by five foster mothers of the attachment behaviors displayed by infants placed in their care. These foster mothers kept daily records of each infant's response to three types of distress likely to occur in a day. The infant's first reaction to the distress and the infant's response to the parent's reaction were coded as secure, resistant, or avoidant. Changes in diary records were examined from as close to the first day as possible after placement up to the 50th to 100th day after placement. Multiple data points allowed analyses at the single subject level.

In examining the evolution of the attachment between a foster child and his or her new foster mother we were interested in whether and how infant attachment behaviors stabilized, perhaps yielding a consistent picture of strategies used. Daily tracking allowed an examination of perturbations in attachment behaviors as the result of such things as separations from the foster mother. There were many reasons to expect babies to show predominately resistant and avoidant behaviors with their new foster mothers, including previous maltreatment and the history of disrupted attachment relationships. Therefore, it seemed that only those babies of foster mothers with secure working models of attachment would have a chance of showing predominately secure behavior in their newly evolving relationships. Further, children placed at younger ages with secure foster mothers were expected to be more likely to show secure behaviors than were children placed later.

The data from these five children provide preliminary support for our hypotheses. First, only those two children placed at a young age (Child 1 and 2) with foster mothers who had secure working models appeared to be developing secure attachments according to the diary data. Indeed, Strange Situations revealed that both children had formed secure attachments to their foster mothers. The two children placed at later ages (Child 3 and 5) with secure foster mothers appeared to be developing avoidant or resistant attachments. The one child (Child 4) placed with a dismissing foster mother at a late age showed little organization of attachment strategies in the diary data. The development of a primarily disorganized attachment strategy with an underlying avoidant strategy was verified by Strange Situation data.

We suggest that the diary recordings of foster mothers provide an exciting way to view the evolution of an attachment because they allow daily records of child attachment behaviors. These daily recordings permit analyses at the single subject level, which is critical to exploring the meaning to children of experiences such as separations from foster mothers and visits with biological mothers. The frequency of these recordings also provides a unique method for closely following the evolution of a new attachment.

Assessing Family Conditions within Low-Income Communities

Martha Abbott-Shim, Joanne R. Nurss

Presenters: Martha Abbott-Shim, Joanne R. Nurss

"Assessing Family Conditions within Low Income Communities" was one of five initial studies funded by the Foundation for Child Development's Neighborhood Research Grants Program. The purpose of the research was to develop and pilot measures to assess change in a variety of family and community conditions within two low-income urban neighborhoods. The underlying assumption of this research is that children's development can best be understood by examining the interrelationships of the systems surrounding the young child rather than viewing the child in isolation. The ecological contexts of family, neighborhood, school, and community all have a bearing on the child's development and must be considered.

A multimeasure protocol was developed to assess relationships between neighborhood conditions and aspects of family functioning and the home learning environment. Measures included demographic descriptions of the families; an interview in which caregivers described the home learning environment; an assessment of the accessibility of and barriers to community services; and ratings of the adequacy of their family resources and social support and of the occurrence of family stress. These measures were chosen to represent aspects of the ecological context of the neighborhood and family functioning shown in the literature to be important to young children's development. Of particular interest was the question of whether differences within low-income neighborhoods could be detected. Most prior research has concentrated either on describing low-income neighborhoods as if they were homogeneous or on delineating differences between low- and middle-income neighborhoods and families. It was assumed that if instruments were sensitive to differences between low-income neighborhoods, they would also be sensitive to changes resulting from interventions in the communities. Although this research did not include such interventions, one objective was to develop a protocol that would measure effects of such efforts.

Data were collected by teams of trained interviewers and neighborhood escorts in door-to-door canvassing in designated neighborhoods (within blocks selected by convenience sampling). Personal interviews were conducted with the primary caregiver in all households with a child under age six years. Both neighborhoods consisted of low-income, predominantly African-American families, most of whom lived in either public or subsidized housing. One community, Milltown, was an older, more intact neighborhood surrounding a former cotton mill. The other community, Downtown, was more transient, less well defined historically, and more geographically spread out. Significant differences were found between the two neighborhoods on several measures.

The final report includes a discussion of protocol development, data collection, data analysis, dissemination, conclusions, recommendations for further research, and the Family Context Interview protocol. It is available from: Foundation for Child Development, 345 East 46th Street, New York, NY 10017.

Stressors: Poverty and Its Ramifications

It's a Different World: Implications for Early Childhood Programs in the African-American Community

Carolyn H. Jarvis, Deborah W. Allen

Presenters: Carolyn H. Jarvis, Deborah W. Allen

This paper presents demographic information collected by the Head Start/Public School Transition Project evaluation for 444 families with young children who live in an historic African-American community, the Bedford Stuyvesant section of Brooklyn, NY. Implications for early childhood programs are discussed.

Most parents were African American (82%) or Latino (16%), and 20% were born outside the United States, usually in the Caribbean or Central America. The average mother's age was 32 years with a range from 20 to 50 years. Parents had varying amounts of formal schooling. While a few parents only attended elementary school and 42% never finished high school, 27% had high school diplomas or GEDs, and 29% had attended some college or earned AA or BA degrees. Few parents (25%) were employed; 60% of the families reported monthly incomes of less than \$800; and 78% received some type of public assistance including Medicaid (73%), food stamps (62%), and AFDC (50%).

About 39% of the families contained one adult, usually the child's mother; 26% were "traditional nuclear two-parent families"; and 26% were extended families that included at least one parent and one to seven other adults. Some children (14%) lived with neither parent. About half the mothers in single-adult households reported that other adults, usually the child's grandmother (25%) or father (19%) helped them with child care and provided other support. Although 86% of the parents described their physical health as good, 70% reported being depressed at some time.

Families in urban neighborhoods throughout the country have been touched by economic and social change. Communities are much more multicultural. Blue collar jobs have disappeared; poverty and homelessness have escalated; and AIDS and crack cocaine, which were unknown 15 years ago, have destroyed numbers of lives. At present, public policies that support poor families are being altered dramatically.

The data show that there is no average or typical African-American family for which programs can be planned. Because of differences in age, education, employment, nationality, etc., programs must plan a wide variety of different parent involvement activities.

Programs should acknowledge the important roles that grandmothers, fathers, and other family members play in children's lives outside of school and design activities specifically for them.

Parents, especially those from other countries, may have very different expectations regarding the roles of children, parents, and teachers, and little knowledge about school policies. Programs should discuss school practices and policies with parents. Since not all parents will attend meetings, multiple methods have to be developed to communicate important information.

Staff must be sensitive to the fact that many parents feel very stressed and may also be depressed. In general, depressed parents will be less responsive to their children's needs and less likely to participate in school activities. Finally, new welfare reform measures will have major consequences for families who depend on public assistance. Staff must be prepared to act as advocates for families as new policies are put into place.

BEST COPY AVAILABLE

669

Resilience, Family Stability, and Family Stress in Preschoolers Who Live in Poverty

Elizabeth E. LaVergne-Pinkett

Presenter: Elizabeth LaVergne-Pinkett

This study examined the relationship between family stability, family stress, and resilience in preschoolers living in poverty. It was hypothesized that there is a greater degree of stability and fewer stressful events in families of resilient children than in families of nonresilient children. Participants consisted of 61 three-, four-, and five-year-old preschool children from three child development centers serving families who live in poverty and are primarily single family. The mean age was 48 months, with a standard deviation of 6.56 months and a range of 36-61 months. There were 38 boys and 23 girls. The sample was comprised of 18 African-American, 15 White, 16 Latino, 11 biracial children, and 1 Native American child. Data were gathered on family stability, stressful life events, and specific dimensions of social and cognitive functioning. Sandler's and Block's modified version of Coddington's Life Events Scale for Children was used to assess the occurrence and type of stressful life events in the family within the 12 months immediately preceding the time during which the parents completed the questionnaire. Family stability was assessed with the Family Demographic Information List (F-DIL), which was developed for this study. Dimensions of family stability were mobility, employment history, and marital patterns. Identification of resilient and nonresilient children was based on the specified dimensions of affective and cognitive functioning. As a result of this process, 14 children were identified as resilient and 47 children as nonresilient.

Findings from a series of Chi-square analyses indicated that 1) families of resilient children appeared to be more stable than families of the nonresilient group as indicated by mobility and employment patterns; and 2) fathers of the resilient group were more likely to have never married, whereas, fathers of the nonresilient group were more likely to have had multiple marriages. No significant findings occurred for mothers' marital patterns. Findings from a one-way ANOVA indicated that during the preceding 12 months, families of nonresilient children had experienced significantly more stress than families of resilient children. The findings suggest that resilient children who live in poverty are more likely than nonresilient children who live in poverty to come from stable and stress-free homes. The identification of family stability as a characteristic common among resilient children has implications for helping children from families exhibiting patterns of instability acquire coping skills and develop resilience. It is likely that parents' response to stress causes them to view events as nonstressful, whereas parents of nonresilient children may respond to stressful events in a manner different from parents of resilient children. Consequently, these findings suggest that a modification of response to stress-producing events can contribute to children's development of resilience.

Stressors: Poverty and Its Ramifications

A Critical Review of Program Design and Methodology in Child and Adolescent Treatment Foster Care Outcome Research

Linda A. Reddy, Steven I. Pfeiffer, Joseph B. McGlinchey, Nancy M. Watt

Presenters: Linda A. Reddy, Steven I. Pfeiffer, Joseph B. McGlinchey, Nancy M. Watt

Treatment foster care is increasingly viewed as a viable alternative to residential and hospital care, producing comparable behavioral improvements in a less expensive and less restrictive treatment setting. As demands increase to document the efficacy of treatment services, careful consideration must be made to the design of treatment foster care programs and the evaluation tools used to assess program effectiveness. To date, investigations have yet to critically review the existing treatment foster care outcome literature on the key elements of program design and methodology. This study offers a comprehensive and integrative review of the training and treatment components of treatment foster care models and a critical examination of the methodology used to evaluate services.

This review examined 40 treatment foster care outcome investigations published from 1974 to 1996. The pool included six infant and preschool studies (0-5 years), nine child studies (5-12 years), nine adolescent studies (12-21 years), and 16 combined child/adolescent studies (5-21 years). A precise coding system was used to review and code the literature on 50 variables across two areas, program design and methodology, including six dimensions: sample characteristics, treatment parent training and support services, child and family interventions and services, research design, evaluation approach, and method of analysis.

The primary finding was that shortcomings in reports of program design and methodology plagued the great majority of the outcome studies, suggesting that definitive conclusions about the effectiveness of treatment foster care are less clear than previously believed. For example, limited data were reported on child, biological family, and treatment foster care parents' characteristics and backgrounds. Surprisingly, few studies adequately described the training and support services supplied to treatment parents and the type, intensity, and duration of child and family interventions and services that were offered. Many studies also reported vague descriptions of research design, dependent variables, methods of data collection, sources of outcome data, and stages of data collection. Studies provided sparse intermediate and follow-up data, limited use of comparison groups, infrequent use of basic statistical analyses, and employed imprecise outcome measures. Suggestions are offered to assist researchers in conceptualizing, designing, and evaluating treatment foster care services for children and adolescents.

Effectiveness of Treatment Foster Care with Children and Adolescents: A Review of Outcome Studies

Linda A. Reddy, Steven I. Pfeiffer, Joseph B. McGlinchey, Nancy M. Watt

Presenters: Linda A. Reddy, Steven I. Pfeiffer, Joseph B. McGlinchey, Nancy M. Watt

Treatment foster care is emerging as a key component in the system of care for children with emotional, behavioral, and medical handicapping conditions, as an outgrowth of fiscal considerations and philosophical and political interest in family-centered and community-based services. Since the early 1950s and increasingly in recent years, treatment foster care programs have aimed at meeting the needs of children who require both the intensive structure of residential care and who benefit from the influence of a "true" family environment. Despite the enormous program development and political interest in treatment foster care, little evidence exists on the efficacy of the model.

The present study evaluated the effectiveness of treatment foster care with children and adolescents. A total of 40 treatment foster care outcome studies including 12,282 subjects were systematically reviewed and analyzed. A structured review coding system was designed to review and code the 40 outcome studies on 25 variables across three dimensions: sample characteristics, training and support services provided to treatment parents, and type of child and family interventions offered. A Weighted Predictive Value (WPV) statistic was used to analyze the impact of treatment foster care on five of the most often studied dependent variables in the existing literature: placement permanency, behavior problems, discharge status, social skills, and psychological adjustment. A total of 25 dependent variables were studied in the literature. Treatment foster care produced large positive effects on increasing placement permanency—children remaining in the same treatment home. For the most part, studies reported that children served in treatment foster care completed the program as expected and responded favorably to the milieu of the treatment foster care home. This finding supports the widely held belief that treatment foster care can serve as an effective alternative to residential and hospital care.

Results also revealed that treatment foster care produced a large positive effect on the development of children's social skills. Additionally, medium positive effects were found in reducing children's behavior problems, improving psychological adjustment, and reducing restrictiveness of postdischarge placement. Findings from this review must be cautiously interpreted because of the limited number of outcome studies and lack of methodological rigor employed by many of the investigations. Recommendations to guide future evaluations of treatment foster care and priorities for research are offered.

Family Intervention Makes a Difference: The Positive Effects of the Trenton Transition Project on Parental Involvement, Attendance, and Academic Achievement

Loreen Huffman, Michaela Benson, Janet Gebelt, Horace Phelps

Presenters: Loreen Huffman, Michaela Benson, Janet Gebelt, Horace Phelps

Low-income, minority urban children are vulnerable to academic and social problems, including declining achievement and grade retention. Optimal family functioning and family involvement in the school seem to ameliorate negative effects of poverty. The purpose of this research was to examine the effects of a family-oriented intervention program on the school involvement, attendance, and academic achievement of low-income children in kindergarten and first grade.

The Head Start/Public School Early Childhood Transition Demonstration Project is a national, federally funded project designed to assess the effects of providing Head Start children with social and educational services through the third grade. The program in Trenton provides social services based on a holistic view of the child in the family, while developing structures that support the child's learning and school functioning. Some of the services include: Family Fun Nights at the school; classroom learning support; addressing basic and special needs; and crisis intervention. Participants were 188 mostly African-American, urban families with children in kindergarten and first grade. Transition families received enhanced social services, while control families received no more than those basic services provided by the school.

In the spring of the school year, parents completed the Family Routines Questionnaire and Your Child's Adjustment to School. Academic achievement was assessed individually using the Woodcock-Johnson Tests of Achievement. Attendance was obtained from children's permanent school records. We hypothesized that the Transition parents would show more school involvement and rate their children as better adjusted to school. We also expected Transition children to have higher school attendance and higher academic achievement.

Results indicated several significant group differences. Transition parents communicated with their children more frequently about school than did control parents. Transition children attended school, on average, five more days than children in the control group, and had higher mathematics scores. There were no significant differences in school adjustment or reading scores.

These results suggest that the family-centered, holistic approach to intervention had a positive impact. Transition parents were more likely to discuss school with their children, and kept "in touch" with their child's teacher more frequently. Children's attendance was higher, as was academic performance.

Social services may have enhanced academic achievement directly (e.g., a child receiving eyeglasses) and indirectly (e.g., enabling parents to attend more to children's educational needs). The collaboration between the social worker and teacher may also have resulted in the identification of children at risk for absence and underachievement.

Although it was hypothesized that children receiving services would have better school adjustment scores, this was not supported by the data. It is possible that the intervention had little effect on the classroom or school environment, limiting the impact on children's adjustment to school. Importantly, these results do support the efficacy of an intervention designed to increase the functioning and school involvement of low-income families, some with numerous psychosocial and economic problems. The results of this project appear to be enhanced communication regarding school, higher attendance, and greater academic competence in kindergarten and first grade.

Parent Involvement in Head Start and Kindergarten *Jerry Cline, Rita Giles*

Presenters: Jerry Cline, Rita Giles

The very heavy emphasis placed by Head Start on parent involvement in Center activities, classroom activities, home/school educational coordination, and social services, abruptly ends as soon as each child graduates from Head Start. The National Head Start/Public School Transition project is designed to maintain this emphasis for Head Start families and children through the kindergarten through third grade sequence. This study of five families (from one of the Transition studies) examines the process of parent contact with public schools during the first post-Head Start year, and contrasts this with parent contact with Head Start.

Data were gathered by in-depth interviews with these families and analysis followed the open-coding concept-building system proposed by Corbin and Strauss using an Ethnograph to manage the codes.

The findings and conclusions from the study are as follows:

- 1) Motivating parents to become involved in the education of their children and in the operation of the school to which their children are assigned is not necessarily the most difficult task in increasing parent involvement. Parents may be quite strongly motivated.
- 2) Lack of time, transportation, baby sitting, and other physical barriers to involvement functions are easily overcome.
- 3) Lack of involvement in school functions does not always indicate a lack of interest on the part of parents. On the contrary, it may also mean satisfaction with the school.
- 4) Most importantly, techniques to improve parent involvement start with changes in the approach of school personnel and project planners rather than changes in parents.
- 5) Training for teachers on how to use parent classroom visits needs to be developed, as does teacher training for how to use teacher home visits. Perceiving parents as partners rather than as aides is the goal of such training. Perceiving parents as partners requires that teachers learn to learn from parents about their children.
- 6) Class-wide socials, picnics, dinners, and parent resource rooms should be planned as stepping stones to the perception of schools and buildings as open, accepting, respectful environments. These events are more than ends in themselves and need to be utilized as powerful invitations to parents to come to school. They should be planned to lead to parent support groups, networks, and friendship groups.
- 7) The delivery of social services, as well as counseling, needs to be centered in the building as a step in a strategy to make each building a multipurpose family center capable of producing a just and caring environment.

Head Start Parents and Public School Teachers: Different Perspectives on Parent-Teacher Partnerships

Lin Moore, David L. Brown

Presenters: Lin Moore, David L. Brown

The Texas Head Start Public School Transition Project promotes active involvement by parents with their children's schooling. Survey data revealed that public school teachers' perspectives of family involvement are more school-centered. Parents of former Head Start children have typically experienced more family-centered programs. Interviewed parents reported high levels of school involvement at the kindergarten and first grade levels.

The Family Involvement Survey measured 131 kindergarten and first grade teachers' attitudes about parent-teacher relationships. A field observer recorded teachers' opinions at teacher-training sessions. Interviewers administered Your Child's Adjustment to School to parents of 203 former Head Start children enrolled in kindergarten and first grade. Parents rated child adjustment and reported school involvement.

Thirty-two public schools in one urban and one suburban school district were randomly assigned to Demonstration or Comparison groups. Teachers in Demonstration schools received training and support for developmentally appropriate practices, including parent involvement. Family Service Providers assessed family needs and facilitated support services in Demonstration schools. Parents were offered opportunities to learn methods to help children with school work, and a parent resource room was opened in each district.

An experimental design compared schools receiving intervention services with controls. Analysis of variance tests compared intervention groups and grade levels. Parent involvement rates were correlated with their child's levels of adjustment.

The findings of the study were as follows:

1) Family Involvement Survey: No significant differences were found between Demonstration and Comparison school teachers. Both kindergarten and first grade teachers strongly endorsed making personal contacts phone calls, encouraging parent visits, recruiting parent volunteers, informing about the child's day, and locating children's services. Teachers were least supportive of making home visits, providing toy lending libraries, sponsoring social activities, and locating family services. Teachers strongly recommended parenting education. Most teachers were positive about working with parents.

2) Qualitative Data: In workshops and focus groups, teachers expressed views that corroborated the survey findings. Teachers saw parents as less school-involved than parents saw themselves. Although teachers perceived themselves to be highly responsive to parents, they were sensitive to criticism by parents and skeptical about the efficacy of their interaction with parents. Some felt schools should house family services, others thought social services belonged elsewhere. Generally, teachers opposed home visiting; welcomed parents' drop-in visits; held parents responsible for children's behavior problems; advocated more parenting education; and recognized the need for more parent-teacher partnership training.

3) Your Child's Adjustment to School and Family Involvement Items: All parents reported positive school adjustment for children. Parents reported daily discussions with child about school as most frequent, with lower rates of talking with teachers, attending school activities, and volunteering. For parents of kindergartners, frequency of discus-

sions correlated positively with the school satisfying their child's social/emotional needs; frequency of participation in school activities correlated positively with their child's satisfactory peer relationships. For parents of first graders, frequency of daily discussions correlated negatively with how well their child did in school.

Successful partnerships can be achieved only when genuinely endorsed by teachers and parents. Although policies can mandate collaboration, effectiveness will be dependent on provisions of support personnel, training for parents and professionals, and resources to implement objectives. Additional research is needed to determine the best strategies for creating family-centered schools.

Developmentally Appropriate Practice and Student Achievement in Inner-City Schools

Carey Wexler Sherman, Daniel P. Mueller

Presenter: Daniel P. Mueller

While the beneficial effects of developmentally appropriate practice (DAP) have been supported by extensive research at the preschool level, there has been little research examining the relationship of DAP to student achievement in the primary grades. This paper examines the implementation of DAP in the early elementary grades as part of the St. Paul Head Start/Public School Transition Demonstration Project, and the relationship of DAP to student achievement. The presence of DAP in kindergarten to second grade classrooms at six inner-city schools (three Demonstration, three Comparison) is measured using the Assessment Profile of Early Childhood Programs-Research Version. Student achievement is measured in two cohorts of students being studied longitudinally using the Woodcock-Johnson Achievement Tests. All study students are from low-income families; half attended Head Start.

Findings indicated that DAP was present to a larger degree in Demonstration than Comparison classrooms, although the overall level of DAP implementation in study classrooms was moderate. Evidence was found for a positive relationship between DAP and student achievement in reading and mathematics. The possibility of a differential effect of DAP upon student achievement by culture was not supported; Southeast Asian (Hmong) students were compared to students from other backgrounds. Implications and limitations of the findings are discussed.

Children's Views of Kindergarten and the School Experience: An Anthropological Lens *Debra Skinner*

Presenter: Debra Skinner

An anthropological analysis of children's views of kindergarten was presented. Ethnographers followed 21 Head Start children into 14 kindergarten classrooms. They interviewed children about school and recorded in field notes children's interactions with teachers and peers. Findings indicated that children were excited about going to kindergarten and the "big school." They did worry, however, that they would not know anyone in their class, and that their teacher might be mean. They were also concerned about losing their way in school and riding the bus.

Children's expressions of likes and dislikes of kindergarten were evoked by particular events, and were often short lived and context bound. For the most part, children liked their teachers and wanted to please them. Their favorite activity was playing with friends. They also liked the "Specials," especially PE and Art. They wanted to learn how to write letters and their names, and were excited when they could do so. Basically what the children liked and what engaged them were active learning experiences where they could move around, do hands-on activities, and interact with other children.

Children also expressed dislikes about school. They did not like time-out or other methods of controlling their behavior. They did not like it when they were not allowed to go outside or choose their own centers. They showed the most frustration when they were engaged in some task they were enjoying, and then were made to stop for the next scheduled activity. The type of classroom activity that caused them the most problems was large group gatherings where they were expected to sit still and listen. During these activities in most of the classrooms, the teacher directed as much time to behavior management as to the lesson at hand.

Many of the children had a good grasp of the rules of the classroom. Head Start had prepared them for many classroom routines. Over half of the children were enacting teachers' expectations and were judged to be good students. However, some were resistant to teachers' demands. They were seen as "defiant," "disobedient," or as "having little self-control." From the children's perspectives, teachers' demands or school restrictions were sometimes seen as unfair. For instance, some school activities meant to encourage reading served to differentiate students by income levels, leading to episodic events for poorer children. Teachers structured space and time according to ideas of developmentally appropriate practice, but children resisted certain structures and attempted to create alternative activities. Many behaviors labeled inappropriate by teachers, like doing two tasks at once, were viewed favorably by the children.

Examining school and children's actions from a child's perspective gives adults another view of classrooms and the children who inhabit them. Children's experiences in school provide a basis for their views of themselves within that environment—views that are significant for their later academic performance. An anthropological look at children's experiences in the classroom highlights the ways in which schools act to produce failure and (re)produce difference.

Health Effects: Head Start/Public Schools Transition Project*Helen Raikes, Beatty Brasch, Linda Hellerich-Tuttle*

Presenters: Helen Raikes, Linda Hellerich-Tuttle, Beatty Brasch

The program for which data were presented is the Head Start Public Schools Transition Demonstration Project. The Nebraska site is 1 of 31 participating in the federal project designed to provide Head Start-like services to children from five demonstration schools from kindergarten through third grade between 1992-93 and 1996-97. The project is a partnership of Lincoln Action Program (grantee), Lincoln Public Schools, and SRI Institute (a division of The Gallup Organization). The research focuses on three questions: 1) how important is children's perceived health to school success; 2) do parents and teachers have similar perceptions of children's health status; and 3) did Transition Project services have an impact on children's health?

The research sample included three groups: project children and families from the five project schools; the comparison group children and families from the six comparison schools; and "intense service families" and their children, who had received a minimum of 18 months of case management. Dependent variables were obtained from a child health questionnaire (including both teacher and parent responses to a question about the child's general health); the Peabody Picture Vocabulary Test; the Woodcock Johnson Tests of Achievement; the Academic Competence Scale (teacher response); and "What I Think of School" questionnaire (children). Days absent from school were also noted.

Results indicated that teacher ratings of children's health were significantly correlated to school success variables, especially in kindergarten. Parents tended to think children's health was better than what teachers thought. Teachers' ratings of children's health became higher over time. Transition appeared to have had some effects on children's health as perceived by teachers.

Project children had higher percentage gains in teachers' perception of general health from kindergarten to later years than was true for comparison group children. Children whose families received intense case management services had the greatest improvement in ratings of general health. Project children had fewer uncorrected visions and hearing problems at all grade levels.

There are five conclusions that can be drawn from this study: 1) parents are more positive about children's general health than teachers are; 2) Head Start-like services in schools appear to lead to better identification of correctable problems; 3) children's general health, as perceived by teachers, may improve more in schools that have Head Start-like services. (Alternatively, because project children had lower scores at baseline, "improvement" may be due to regression towards the mean.); 4) children's general health as perceived by teachers seems to improve appreciably as a function of intense case management; and 5) children's general health, as perceived by the teacher, is associated with and important to school success, especially in the early elementary school years.

Transition

Providing Head Start-Like Service from Kindergarten through the Third Grade: The Role of Family Service Coordinators

Sharon M. Allen, Ray H. Thompson, Jane Drapeaux

Presenter: Ray H. Thompson

The Head Start experience has recently been expanded into elementary schools through implementation of the National Head Start/Public School Transition Research Project (NTP). The NTP is a school-based intervention program implemented in 1992 to improve outcomes for students at risk. One half of the children and families receive NTP services and the other half serve as comparison children and families.

The South Dakota Head Start/Public School Transition Project (SDTP) is one of the 31 NTP sites and is comprised of five demonstration and five comparison local sites. Family Service Coordinators (FSCs) provide comprehensive Head Start-like services to children and families at each of the five demonstration sites. Services are provided in the areas of social services, health, education, and parent involvement. The FSCs make routine home visits and work directly with parents in an effort to improve home-school communication, provide the parents with educational resources, and help parents gain access to needed social services. The teachers at demonstration schools receive training through the SDTP on the use of developmentally appropriate classroom practices (DAPs), as well as encouragement and limited assistance from the FSCs.

The qualitative study gathers descriptive data through interviews, observations, and analysis of FSC journals. Interviews are conducted with teachers, principals, and parents from demonstration and comparison sites and with FSCs. Observations are conducted at schools, home visits, and community meetings in the demonstration sites. The qualitative study is ongoing and supplements the NTP core data set.

Preliminary results indicate that demonstration parents have been empowered through their acquisition of needed social services, involvement in SDTP as officers and governing board members, increased involvement in schools, and improved interaction with teachers and principals. Most demonstration classrooms have increased their usage of DAPs and parents in the classrooms. Many of the demonstration schools have changed their view of the students from just the educational domain to that of the "whole child." The liaison function of the FSCs has assisted in the transformation of schools; improved communication between school and home; and increased levels of parent involvement in schools. Parents whose children attend demonstration schools are more comfortable in the schools and in their children's classrooms.

Parents are pleased with the SDTP in general and with home visits and assistance from the FSCs in particular. Parents have formed close relationships with their FSCs and enjoy having someone with whom they can talk. Parents especially appreciate hearing about their children's educational experience from someone other than their children's teachers.

Teachers and principals in demonstration schools enjoy the liaison function of FSCs. Teachers and principals feel they know the children better and feel like schools have closer contact to parents. Most principals feel that the schools are able to make better decisions regarding the children's education because of the SDTP.

The SDTP is funded through a grant from the U.S. Department of Health and Human Services to South Central Child Development, Inc., Wagner, South Dakota, with a sub-award to the InTEC Center at the University of South Dakota.

A Head Start Transition Project in the Public Schools: Teacher and Principal Beliefs Concerning Program Implementation and Developmentally Appropriate Practices

Stacey Neuhaarth-Pritchett, Panayota Youli Mantzicopoulos

Presenters: Stacey Neuhaarth-Pritchett, Panayota Youli Mantzicopoulos

To date, evaluations of the effectiveness of Head Start have relied on comparisons of students who attended Head Start with similar groups of students who did not attend Head Start. In these studies, little or no attention was paid to the contextual influences that might affect the outcomes of interest. This study differs from the already existing research on Head Start in that it examines qualitatively 1) teacher and principal perceptions of the strengths and weaknesses of a Head Start Transition Project; and 2) the perceptions of teachers with equivalent training in developmentally appropriate instructional practices (DAP) about the implementation of those practices in their classrooms.

Principals' perceptions of the strengths of the program centered around three main themes that included 1) the value of having additional adults working with children in the program; 2) improvements in the home-school relationship; and 3) enhanced school adjustment for children.

All groups of teachers viewed the transition service providers in their schools as a significant program strength. Other teacher perceptions of strengths included continuity for children and families within the program; the social service extension of the program; counseling services; increased knowledge of children's needs; and extra funds for materials.

Few program weaknesses were noted by the principals. However, teachers across grade levels reported a number of barriers, some of which were grade-specific. Concerns identified by almost all teachers included 1) insufficient provision of time for communication between teachers; 2) need for more information about the outcomes of referrals made to social service staff; 3) the difficulties in getting low-income parents involved in the schools; 4) classroom discipline issues in an active-learning classroom environment; 5) the seemingly incompatible nature of DAP with the "testing" focus of the school system; 6) the need to improve the feedback process from social service providers; and 7) scheduling difficulties with classroom aides.

Teachers reported that they had a number of opportunities to participate in training. Moreover, they commented positively on the content and appropriateness of the transition workshops. In addition, principals noted that they had input into the planning of activities and considered the training to be helpful and consistent with teachers' curriculum goals and those of the school corporation.

Principals noted that transition teachers' curriculum goals were consistent with those established by the school district and the state. Two principals commented on the provision of extra instructional materials that were age-appropriate and thus likely to enhance instruction. Only one principal of the three voiced the concern that the DAP did not adequately address classroom discipline. Principals further cited a diminished amount of referrals of children with behavior problems enrolled in transition classrooms.

Teachers commented positively on the instructional approach emphasized by the program. They noted that DAP as was implemented in their classrooms was 1) consistent with their curriculum goals; and 2) conducive to student development and motivation. Teacher statements did, however, support the assertion that the transition program's instructional orientation was not fully compatible with the school district's focus on standardized achievement test results.

Determinants of Parents' Satisfaction with Head Start and Transition Children's After-School Activities

Sylvia W. Sirignano, Beth M. Miller, Susan O'Connor

Presenters: Sylvia W. Sirignano, Beth M. Miller, Susan O'Connor

The present study examined parents' satisfaction with the after-school activities of children in Head Start, and children in kindergarten and first grade Head Start Transition classes. The data for the study came from the Head Start/Transition Out-of-School Time Project at the School-Age Child Care Project, Wellesley College Center for Research on Women. A number of characteristics of the children, their families, and after-school activities were examined.

Families were randomly selected for this study from three Transition Demonstration Program sites funded by the Administration on Children, Youth and Families. The sites were chosen to represent mid-sized cities with geographic diversity (one each from the northeastern region, the midwest, and the west coast). Across the three sites, 180 families participated in the study (60 families from each site) with sampling stratified by child grade, gender, and cultural/ethnic background.

Personal interviews, lasting between one and one and one-half hours, were conducted by interviewers who shared the families' linguistic and ethnic backgrounds. The Family Interview was developed by the senior research team, with some sections based on revisions of existing instruments. A parent satisfaction scale was developed for the interview, asking parents to rate their satisfaction with a variety of aspects of after-school time. Children's activities were coded from open-ended questions asking parents which three activities their child spent the most time doing after school during a typical week.

After-school arrangements were grouped into three categories for analysis: home with mother (or other primary caregiver), including four children who spent a few hours/week in a neighborhood drop-in recreational center ($N=128$); under someone else's care in the child's home or in the caregiver's home ($N=28$); and enrolled in an after-school program or structured lessons or activities, such as music lessons or religious instruction ($N=23$).

The pattern of results indicates that where children spend their time after school, as long as they are well supervised, does not affect parents' satisfaction, while specific aspects of what the children are doing does. Parents were most satisfied if they perceived that their children were happy with their after-school time and engaged in developmentally appropriate play with other children. For example, satisfaction did not differ between those parents whose children spent time in school-related learning activities, or chores, and those whose children did not. Parents also were more satisfied if they received help with planning for after-school time from Head Start or Transition staff.

Parents whose children spent some time under the supervision of a child under 12 years old were not satisfied with this arrangement. Obviously, these parents felt they had no other choice. Future analyses of these data are needed to better understand the barriers these parents experience in their attempts to arrange more satisfactory supervision during after-school time.

Early Transition to Public School: Children's School Achievement and Adjustment from Head Start to Second Grade*Panayota Youli Mantzicopoulos, Stacey Neuhaith-Pritchett**Presenters: Panayota Youli Mantzicopoulos, Stacey Neuhaith-Pritchett*

The purpose of this investigation was to explore the effects of a federally funded Head Start Public School Transition Program in a Midwestern school district in its first three years of operation. Specifically, the study addressed the extent to which previous Head Start attendees, who entered a "Transition" public school, experienced gains in social and cognitive competence when compared to their peers who attended public schools without the extra provision of transition services. The sample comprised 50 children (29 transition and 21 comparison) who consistently remained in a regular transition or comparison classroom until the end of second grade.

Baseline data on cognitive ability, preacademic achievement, and socioemotional adjustment were collected during the Head Start year. Follow-up data were gathered at the spring of each grade level (kindergarten, first, and second) on academic achievement, problem behaviors, social skills, and school adjustment. Parents also reported on the extent to which they were pleased with the schools' approach to meeting their children's cognitive and socioemotional needs.

The analyses of academic outcomes yielded mixed results. The most consistent differences between the groups emerged at first grade with transition children outperforming their comparison peers on three of the four subtests of the individually administered Woodcock-Johnson battery. However, at the end of second grade there were no consistent differences between the groups. Nevertheless, teacher and parent ratings of academic/cognitive competence characterized transition students as more educationally competent than their comparison peers.

Children in the two groups also differed on social adjustment characteristics throughout the three-year period of the study. Transition teachers described their students as better adjusted, less behaviorally troubled, and more socially competent. Additional information on children's school adjustment was obtained from individual interviews with parents of transition and comparison children. The analysis of these data suggested that transition children, in contrast to their comparison peers, were reported to 1) have more positive relationships with their teachers; 2) have more positive peer interactions; and 3) be better adjusted in school.

Further analyses were conducted to examine differences in levels of parental satisfaction with school programs. Results indicated that transition parents were more likely than comparison parents to report being satisfied with the transition schools' approach to promoting children's social development and meeting children's social and emotional needs.

In conclusion, the results suggest that more positive effects were obtained at the end of the first-grade year and that some positive effects did not hold (e.g., the differences on achievement) at second grade. Changes that occurred in the project at the onset of second grade (e.g., change in project directors and the teacher training model) may have introduced a period of adjustment and instability that may have influenced the outcomes of the study indirectly. It is expected that information from the analyses of interview protocols with teachers and transition program providers will clarify some of these influences. In addition, the longitudinal follow-up of the sample will allow further examination of the observed trends and will provide additional evidence on the long-term impact of the transition intervention.

Impact of the Cognitive Education Model (COGNET) on At-Risk Children and Their Teachers *Katherine Greenberg*

Presenters: Katherine Greenberg, Sandra Machleit

The Cognitive Enrichment Network Education Model (COGNET) is a program designed to establish a parent/teacher partnership through which high-risk children can develop thinking skills and achieve greater school success. Approved by the National Diffusion Network (NDN) in 1995, COGNET helps children become effective, independent, life-long learners who are able to adapt to an ever-changing world and to act as responsible members of society by building a foundation for effective critical thinking through the use of cognitive processes and affective/motivational approaches. COGNET combines a unique approach to teaching children how to learn with best practices in education based on compatible theory and supported by research. COGNET teaches children to develop their own strategies in virtually any academic or nonacademic setting that can be used from preschool through graduate school. Key components of COGNET include: 1) a mediated-learning classroom approach that incorporates 10 Building Blocks of Thinking, 8 Tools of Independent Learning, and a process-oriented child-centered classroom atmosphere; 2) parent/school learning-to-learn partnership; 3) supportive implementation network; and 4) theory and research-based practices.

The purpose of this research was to study the effects of COGNET on academic achievement of at-risk students across a variety of settings and to study the effects of COGNET on teachers' ability to facilitate higher order thinking and learning through the use of mediated learning techniques. The primary outcome indicators of academic achievement were based on standardized tests to ensure equivalent data between groups. All four studies used comparison groups in an attempt to control for the change in student data possibly attributed to maturation. Reliability of the results is enhanced by data reported for several cohorts of environmentally and ethnically different groups of students in four different treatment schools and represents two different time periods (1988-91 and 1991-94). All comparison groups were matched to their treatment groups based on grade level, geographical location, characteristics of the families served within the school, and whether or not both participated in designated Chapter I Schoolwide Project Schools.

Two studies of COGNET impact on teacher behaviors in urban and rural settings indicated that teachers in the urban study were characterized as displaying greater intentionality, transcendence, purpose of lesson, level of assistance, strategic teaching, and change in their interactions with children during instructional activities in elementary classrooms. The rural study found that COGNET teachers scored at higher levels of use of mediated learning than untrained teachers.

Conclusions from the research indicate that high-risk students in the COGNET schools made greater gains overall than comparison groups on standardized tests of basic skills as reflected by gains exceeding those expected based on national norms, gains in NCE scores, and in significant decreases in the percentage of students scoring below average on these tests. Teachers in COGNET schools demonstrated more classroom behaviors that facilitate higher order thinking and learning than did teachers in comparison schools. Thus, COGNET's unique design and proven theoretical base provide a decisive advantage in teaching learning-to-learn and basic academic subjects to both high-risk and other children.

The Influence of Family Composition and Parental Involvement on School Achievement

Ithel Jones, C. Stephen White

Presenters: Ithel Jones, C. Stephen White

Parental involvement has long been considered a key component of early educational intervention programs. One of the more compelling reasons for involving parents in their children's schooling is the potential effect it has on improving student achievement. That is, it is generally accepted that when children have a quality school program and supportive and involved parents, they do better academically and socially. From an ecological perspective, young children's functioning in one context is affected by their functioning in other contexts in which they directly participate.

This study tests the general proposition that young children's school achievement is influenced by factors from the family context, including family composition (family size and number of adult caregivers), the parents' educational background, and the type of school-related activities practiced by parents. Participants in the study were 333 students (grades one through three) who attended Follow Through programs in three schools in the southeastern United States. Follow Through was a program designed to make the transition from Head Start into the early grades as smooth as possible. A questionnaire designed to measure parents' attitudes toward school and the extent of their involvement in school-related activities was sent to all parents of children enrolled in first-, second-, and third-grade Follow Through classrooms.

Students selected for the study were those whose parents completed and returned the questionnaire. Test scores for both language and mathematics by students included in the study were provided by school personnel. The data were analyzed using both correlational and regression techniques. As predicted, we found that academic achievement was related to measures of family composition (family size, number of adult caregivers, and parents' educational level). With controls for race and gender, family environment variables accounted for nontrivial portions of variability (3-5%) in the two academic achievement areas of interest: language and mathematics. Furthermore, we found that parents' educational levels were associated with their children's scores on academic achievement tests. The findings also suggest that students whose parents engaged in learning activities at home are likely to obtain higher achievement (language) scores. This study lends support to current practices commonly found in Head Start and other early childhood programs for involving parents in their children's schooling.

Cooperating Organizations and Program Committee

Cooperating Organizations

Ambulatory Pediatric Association	National Association of Elementary School Principals
American Academy of Child and Adolescent Psychiatry	National Association of Social Workers
American Academy of Pediatrics	National Association of State Boards of Education
American Dental Association	National Association of W.I.C. Directors
American Educational Research Association	National Black Child Development Institute, Inc.
American Medical Association	National Black Nurses Association
American Nurses Association	National Council for International Health
American Orthopsychiatric Association	National Center for Children in Poverty
American Public Health Association	National Council of Jewish Women
American Psychiatric Association	National Center for Learning Disabilities
American Psychological Association	National Committee to Prevent Child Abuse
American Psychological Society	National Council on Family Relations
American Speech-Language-Hearing Association	National Fatherhood Institute
Association of Black Psychologists	National Head Start Association
Association of Hispanic Mental Health Professionals	National Latino Children's Association
Association of Maternal and Child Health Programs	National Medical Association
Association of Teachers of Maternal and Child Health	National Mental Health Association
Association for Childhood Education International	The National PTA
Council for Exceptional Children, Division for Early Childhood	The World Association for Infant Mental Health
ERIC Clearinghouse on Elementary and Early Childhood Education	Society for the Advancement of Children's Studies
Family Resource Coalition	Society for Behavioral Pediatrics
International Society for Infant Studies	Society for Nutrition Education
National Association for the Education of Young Children	Society for Research in Adolescents
	Zero to Three National Center for Clinical Infant Programs

Program Committee

Ann S. Bardwell, Ph.D., Drake University
Sue Bredekamp, Ph.D., Director of Professional Development, NAEYC
Cynthia Garcia-Coll, Ph.D., Brown University, Representative, SRCD
Sarah M. Greene, CEO, National Head Start Association
John Hagen, Ph.D., Executive Officer, SRCD
Willie James Epps, Ph.D., Director, Southern Illinois University
Gloria Johnson-Powell, M.D., Harvard Medical School
Esther Kresh, Ph.D., Federal Project Officer, ACYF
Faith Lamb Parker, Ph.D., Project Director, Columbia University
John Pascoe, M.D., University of Wisconsin-Madison
Deborah Phillips, Ph.D., Director, Board on Children and Families, National Academy of Sciences
Mary Bruce Webb, Ph.D., Social Science Research Analyst, ACYF

Peer Reviewers

- Martha S. Abbott-Shim, Ph.D.
 Lois W. Abramczyk, M.S.S.W., Ed.D.
 Catherine C. Ayoub, Ed.D.
 Amy J. Baker, Ph.D.
 Rosemary Barber-Madden, Ed.D.
 Ann S. Bardwell, Ph.D.
 Lula A. Beatty, Ph.D.
 Sonya Bernporad, M.A.
 Rita K. Benn, Ph.D.
 John R. Bergan, Ph.D.
 Carol Berman, Ph.D., M.A.
 Jan B. Blacher, Ph.D.
 Judith S. Bloch, M.S.W.
 Donald P. Bolce, A.B.
 Barbara L. Bonner, Ph.D.
 Sue Bredekamp, Ph.D.
 Jeanne Brooks-Gunn, Ph.D.
 Dorothy C. Browne, Ph.D.
 Katharine G. Butler, Ph.D.
 Frances A. Campbell, Ph.D.
 Meredith Censullo, Ph.D.
 Mary Anne Chalkley, Ph.D.
 Bernard Challenor, M.D., M.P.H.
 Albert Chang, M.D.
 Roseanne Clark, Ph.D.
 Michele B. Cole, J.D.
 Joan Costello, Ph.D.
 Catherine Cowell, Ph.D.
 Maria A. Crisafi, Ph.D.
 Nicholas Cunningham, M.D., Ph.D.
 William A. Darity, Jr., Ph.D.
 Lois-Ellin G. Datta, Ph.D.
 Andrew Davidson, Ph.D.
 Larry W. Desch, M.D.
 David K. Dickinson, Ed.D.
 Laura L. Dittmann, Ph.D.
 Felton J. Earls, M.D.
 Patricia A. Edwards, Ph.D.
 Dawn C. Ellis, M.S.
 Robert N. Emde, M.D.
 Doris R. Entwistle, Ph.D.
 Willie J. Epps, Ph.D.
 Joyce L. Epstein, Ph.D.
 Linda Espinosa, Ph.D.
 David Evans, Ph.D.
 Dale C. Farran, Ph.D.
 Jason K. Feld, Ph.D.
 Janet E. Fischel, Ph.D.
 Michael J. Flahive, Ph.D.
 Rowena Fong, Ed.D., M.S.W.
 Paul J. Frick, Ph.D.
 Bruce Fuller, Ph.D.
 Ellen Galinsky, M.S.
 Terri M. Gallmeier, Ph.D.
 Herbert P. Ginsburg, Ph.D.
 Katherine H. Greenberg, Ph.D.
 Daryl B. Greenfield, Ph.D.
 Jonathan J. Greenstein, Ph.D.
 Dominic F. Gullo, Ph.D.
 John W. Hagen, Ph.D.
 Ann H. Hains, Ph.D.
 Sydney L. Hans, Ph.D.
 Cynthia S. Harbeck-Weber, Ph.D.
 Barbara J. Hatcher, Ph.D.
 Harriet Heath, Ph.D.
 James H. Heller, M.A., M.S., A.B.D.
 Gary Holden, D.S.W.
 Susan D. Holloway, Ph.D.
 Alice S. Honig, Ph.D.
 Hyman Hops, Ph.D.
 Patricia D. Horsch, M.A.
 Mark S. Innocenti, Ph.D.
 James E. Johnson, Ph.D.
 Gloria Johnson-Powell
 Sheila D. Jones, Ed.D.
 Sue Kessler-Sklar, Ph.D.
 Ellen E. Kisker, Ph.D.
 Alice S. Klein, Ph.D.
 Nancy K. Klein, Ph.D.
 Lorraine V. Klerman, Ph.D.
 Sally A. Koblinsky, Ph.D.
 Jonathan B. Kotch, M.D.
 J. Ronald Lally, Ed.D.
 Michael E. Lamb, Ph.D.
 Joseph T. Lawton, Ph.D.
 Irving Lazar, Ph.D.
 Bonnie J. Leadbeater, Ph.D.
 Robert K. Leik, Ph.D.
 Martha Lequerica, Ph.D.
 Carol S. Lidz, Ph.D.
 Lewis P. Lipsitt, Ph.D.
 Rebecca A. Marcon, Ph.D.
 Nancy L. Marshall, Ed.D.
 Emanuel J. Mason, Ed.D.
 Ann S. Masten, Ph.D.
 Rosemary D. Mazzatenta, M.S.
 Robert B. McCall, Ph.D.
 Anne McGill-Franzen, Ph.D.
 Gary B. Melton, Ph.D.
 Barbara Merrill, M.A.
 Norweeta G. Milburn, Ph.D.
 Shelby H. Miller, M.A.
 Elba I. Montalvo, M.A.
 Carolyn Morado, Ph.D.
 Frederick J. Morrison, Ph.D.
 Linda Musun-Miller, Ph.D.
 Mary J. O'Connor, Ph.D.
 Sherri L. Oden, Ph.D.
 Jean Osborn, M.E.D.
 Joy D. Ososky, Ph.D.
 Margaret T. Owen, Ph.D.
 Judith S. Palfrey, M.D.
 John M. Pascoe, M.D., M.P.H.
 Lillian A. Phenice, Ph.D.
 Deborah A. Phillips, Ph.D.
 John Poertner, D.S.W.
 Douglas R. Powell, Ph.D.
 Jane L. Powers, Ph.D.
 Adele Proctor, Sc.D.
 Judith V. Ramirez, Ph.D.
 Arnaldo J. Ramos, Ed.D.
 Suzanne M. Randolph, Ph.D.
 Virginia A. Rauh, Sc.D.
 Yvonne B. Reedy, Ph.D.
 Lauren B. Resnick, Ed.D.
 Catherine Riley, B.A.
 Lori A. Roggman, Ph.D.
 Harriett D. Romo, Ph.D.
 Leon A. Rosenberg, Ph.D.
 Rosalyn T. Saltz, Ph.D.
 Amy Schlessman-Frost, Ph.D.
 Richard K. Scotch, Ph.D.
 Victoria R. Seitz, Ph.D.
 Terri L. Shelton, Ph.D.
 Milton F. Shore, Ph.D.
 Mary Lou De Leon Siantz, Ph.D.
 Catherine E. Snow, Ph.D.
 Freya L. Sonenstein, Ph.D.
 Robert G. St. Pierre, Ph.D.
 Prentice Starkey, Ph.D.
 Mark A. Stein, Ph.D.
 Harold W. Stevenson, Ph.D.
 Deborah J. Stipek, Ph.D.
 Lori Connors Tadros, Ph.D.
 Angela R. Taylor, Ph.D.
 Susan Taylor-Brown, Ph.D., M.P.H.
 Yolanda L. Torres, M.A.
 Penelope K. Trickett, Ph.D.
 Brian E. Vaughn, Ph.D.
 Lawrence A. Vitulano, Ph.D.
 Mary M. Wagner, Ph.D.
 Margaret C. Wang, Ph.D.
 Valora Washington, Ph.D.
 Heather Weiss, Ed.D.
 Donald Wertlieb, Ph.D.
 Harry I. Wilson, B.S., M.P.A.
 Modena Wilson, M.D., M.P.H.
 Caroline Zinsser, Ph.D.

Subject Index

- Adolescent parents: 276, 419, 485-487, 548, 552, 623
- Adoption and foster care: 293, 660, 662, 666, 667
- Attachment: 502, 662
- Bilingual/multilingual education: 197, 526
- Child abuse and neglect: 615, 634, 642
- Child care: 242, 250, 253, 265, 490-498, 574, 614
- Child measures/assessment: 133, 145, 147, 612, 616
- Children with special needs: 291, 352, 359, 505-517, 527, 582
- Cognitive development: 129, 130, 253, 277, 500, 501, 534, 584, 590, 591, 650, 652, 653, 678
- Collaborations and partnerships: 43, 57, 89, 102, 106, 352, 402, 423, 453, 468, 540-543, 545, 546, 562
- Community factors: 218, 400, 606, 663, 664
- Community violence: 216, 228, 233, 370, 555, 603, 655
- Curriculum (including developmentally appropriate, teaching methods): 14, 106, 129, 273, 278, 439, 469, 472, 497, 528-539, 621, 671, 675, 678
- Ethnic diversity: 132, 197, 374, 389, 400, 439, 518, 519, 521, 522, 523, 525, 527, 577, 584, 631
- Family ecology/family systems: 128, 129, 131, 544, 591, 664
- Family strengths and adaptive strategies: 132, 281, 446
- Family support services (including self-sufficiency and parenting education): 144, 186, 221, 223, 250, 306, 423, 525, 537, 542, 547-560, 568, 588, 630, 632, 638, 668, 674
- Fathers: 448, 467, 549, 631
- Health: 206, 313, 326, 336, 344, 347, 471, 513, 561, 562, 564, 565, 566, 673
- Homelessness: 284, 655-661
- Infants and toddlers: 116, 242, 279, 309, 567-582, 608, 647
- Intervention
early, alternative comprehensive approaches: 175, 277, 282, 489, 556
home-based: 276, 289, 487, 569, 570, 586, 602, 627, 636
- Language development: 106, 127, 267, 310, 528, 573, 577, 587, 594
- Literacy (including emergent literacy and family literacy)
127, 145, 269, 583, 586, 588, 592, 593, 595, 596
- Low birthweight: 309, 572
- Mental health: 148, 347, 486, 499-504, 508, 598-605, 665
- Methodologies and measures: 62, 133, 149, 306, 374, 389, 400, 402, 406, 522, 531, 606-613
- Multiculturalism: 22, 197, 469, 520, 526, 532, 536
- Normative child development: 279, 614-621
- Nutrition: 317, 563
- Parent-child interaction/parenting skills: 146, 270, 306, 309, 518, 521, 622, 623, 624, 627, 630, 637, 638, 652
- Parent involvement: 468, 470, 488, 592, 593, 595, 626, 628, 629, 632, 634-636, 639, 669, 670, 679
- Parental attitudes and values (including expectations)
307, 492, 585, 590, 625, 676

Play 147 581 616

Program quality: 106 129 427 609

Public policy for children and families 4 16
62 75 242

Resiliency 27 281 360 370 560 633 665

School readiness: 490

Screening and assessment: 512 515 608

Service delivery 128 186 250 326 495 540
541 544 561

Social development (including emotional behavior): 129,
146, 221, 223 233 253 349 491 493 499 500,
503 523 589 598 600 605 613 648 650 651,
653 654

Substance abuse (including effects and prevention): 214,
311 370 450 504 567 577 581 582

Teacher/staff training and development: 106 265 466
520 529 530 532 641-647

Transition 130 163 242 535 668-679

Directory of Participants

Martha S. Abbott-Shim 106, 531, 663
Georgia State University
Center for Study of Adult Literacy
College of Education Building,
Suite 367
University Plaza
Atlanta, GA 30303-3083
mabbottshim@gsu.edu

Saburah Abdul-Kabir
University of Pennsylvania
Department of Education and
Psychology
3700 Walnut Street
Graduate School of Education
Philadelphia, PA 19104

Mehnur Abedin 568
DC General Hospital
1900 Massachusetts Avenue, SE
Washington, DC 20003

J. Lawrence Aber 216
National Center for Children in
Poverty
154 Haven Avenue, 3rd Floor
Columbia University School of
Public Health
New York, NY 10032-1180
jla12@columbia.edu

Lois W. Abramczyk
6301 Westshore Road
Columbia, SC 29206

L. Annette Abrams 43, 89, 546
Michigan State University
VPUO Office
2 Kellogg Center
East Lansing, MI 48824-1022
Abrams@msu.edu

Lauren Abramson
East Baltimore Mental Health
Partnership
1235 East Monument, LL50
Baltimore, MD 21202
labramso@welchlink.welch.
jhu.edu

Consuelo Aceves
83 Brattle Street, #64
Cambridge, MA 02138
acevesco@hugse1.harvard.edu

Beena Achhpal 489, 545
University of Connecticut
School of Family Studies
39-C, Dartmouth Road
Storrs, CT 06268
achhpal@uconnvm.uconn.edu

Brian P. Ackerman 499
University of Delaware
Department of Psychology
224G Wolf Hall
Newark, DE 19716
bpa@strauss.udel.edu

Teresa Y. Acosta 615
University of Texas at Austin
4511 Avenue, G
Austin, TX 78751
teresaa@tenet.edu

Linda A. Acredolo 311
University of California
Department of Psychology
Davis, CA 95616

Emma K. Adam 279, 652
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345
adam0078@gold.tc.umn.edu

Linda B. Adams
Administration on Children, Youth
and Families
Child Care Bureau
200 Independence Avenue, SW
Room 320-F
Washington, DC 20201
lthomas@acf.dhhs.gov

Marilyn A. Adams
3910 West Clinton Avenue
Milwaukee, WI 53209

Mary A. Adams 549
University of Southern Mississippi
Met Program
Southern Station Box 5035
Hattiesburg, MS 39406-5035

Laurelee Ahlman 540,
17335 Kahiltna Drive
Eagle River, AK 99577
ahlman_laurelee@msmail.asd.
k12.ak.us

Bertha Alexander
Vanderbilt University Medical Center
TEIS
2147 Belcourt Avenue, Suite 200
Nashville, TN 37232-8675

Jane Alexander 281
University of Alberta
Center for Research in Applied
Measurement and Evaluation
3-102 Education North
Edmonton, Alberta
Canada T6G 2G5
jane_alexander@psyc.educ.
ualberta.ca

Jessica Alexander
79 Haviland Road
Ridgefield, CT 06877

Abbey Alkon 347, 348, 349
University of California-Berkeley
Harold E. Jones Child Study Center
2425 Atherton Street, Room 22
Berkeley, CA 94720-6070
abbeyalk@uclink2.berkeley.edu

Deborah W. Allen 664
107 West 131st Street
New York, NY 10027

Sharon Allen 674
University of South Dakota
School of Education
414 East Clark
Vermillion, SD 57069

Gloria R. Alston 465, 467
N.E.E.D. Head Start
PO Box 2346
Rocky Mount, NC 27801

Cathy Alvarez
Administration on Children, Youth
and Families
9320 Sparrow Valley Drive
Gaithersburg, MD 20879

Teresa Alvarez-Canino 116
28 West 71st Street
New York, NY 10023

Susan R. Andersen
Iowa Department of Education
Grimes State Office Building
Des Moines, IA 50310-0146
susana1037@aol.com

Elaine A. Anderson 655, 661
University of Maryland
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742

Gene Cranston Anderson 579
Case Western Reserve University
Frances Payne Bolton School of
Nursing
10900 Euclid Avenue
Cleveland, OH 44106-4904
gca@po.cwru.edu

Sheryl E. Anderson 344
Columbia University Head Start
School of Public Health
601 West 168th Street, #42
New York, NY 10032
CR14@columbia.edu

Stephen A. Anderson 545
University of Connecticut
School of Family Studies
348 Mansfield Road, U-58
Storrs, CT 06269-2058

Linda J. Anooshian 658, 659
Boise State University
Department of Psychology
1910 University Drive
Boise, ID 83725-0001
lanooosh@ssafac.kdsu.edu

Bruno J. Anthony 604
University of Maryland-Baltimore
Department of Psychiatry
645 West Redwood Street
Baltimore, MD 20201
banthony@umpsy.ab.umd.edu

Michael C. Anziano
Fort Lewis College
Department of Psychology
108 HH
Durango, CO 81301

Eduardo J. Armijo
University of Washington
C-Stars
4725 30th Avenue, NE
Seattle, WA 98105-4021
armijoed@u.washington.edu

David H. Arnold
University of Massachusetts
Psychology Department
Box 37710
Tobin Hall
Amherst, MA 01003-7710
darnold@psych.umass.edu

Robert Aronson 640
Johns Hopkins University
Department of Maternal and Child
Health
111 Market Place, Suite 850
Baltimore, MD 21201

Edith G. Arrington
University of Virginia
512A Georgetown Road
Charlottesville, VA 22901
ega2t@virginia.edu

Sherri Ash
Administration on Children, Youth
and Families
Head Start Bureau
330 C Street, SW
Switzer Building
Washington, DC 20032

Ann L. Athorp 602
Memorial University of
Newfoundland
University Counselling Centre
St. John's, Newfoundland, Canada
A1C 5S7
aathorp@kean.ucs.mun.ca

Jane Atwater 311, 483
University of Kansas
Juniper Gardens Children's Project
1614 Washington Boulevard
Kansas City, KS 66102
janea@kuhub.cc.ukans.edu

Catherine C. Ayoub 543
Harvard Graduate School of
Education
Appian Way
Larsen Hall, Room 711
Cambridge, MA 02138
ayoubca@hugae1.harvard.edu

Muriel R. Azria 648
Auburn University
Department of Family and Child
Development
School of Human Sciences
Auburn University, AL 36849-5604
mazria@humsci.auburn.edu

Amy J. Baker
NCJW Center for the Child
53 West 23rd Street
6th Floor
New York, NY 10010-4204

Linda Baker 269
University of Maryland-Baltimore
County
Department of Psychology
5401 Wilkens Avenue
Baltimore, MD 21228-5398

Rebekah Baker
Salvation Army Child Care
1515 West Monroe Street
Chicago, IL 60607

D. Catherine Baltzell
901 6th Street, SW, Apartment 310
Washington, DC 20024
baltzellid.hehs@gao.gov

John Bancroft 359
Puget Sound Educational Service
District
Head Start Program
400 SW 152nd Street
Burien, WA 98166-2209
jbancrof@pseed.wcdnet.edu

Mary Bancroft 654
Cornell University
Department of Human Development
and Family Studies
MVR Hall
Ithaca, NY 14853

Mary Jo Bane 1
Administration for Children and
Families
370 L'Enfant Promenade
Washington, DC 20047

Patricia B. Banks 465, 468
16 Pamlico Road
Havelock, NC 28532

Rosemary Barber-Madden 344,
346
7 Stanton Lane
Marlton, NJ 08053-2489

Ann S. Bardwell 289
Drake University Head Start
2507 University Avenue
Des Moines, IA 50311
asb@drake.edu

Kathryn E. Barnard 116, 309
University of Washington
School of Nursing
Box 357920
Room 212, South Building
Seattle, WA 98195-0001
kathyb@u.washington.edu

Steven Barnett 406
Rutgers University
Graduate School of Education
10 Seminary Place
New Brunswick, NJ 08903

Sandra Barrueco
University of Denver
2155 South Race Street
Frontier Hall
Denver, CO 80222

Mary J. Baskerville 640
Hartford Head Start
Community Renewal Team
55 Windsor Street
Hartford, CT 06120

Millie Baskin
7035 Marbury Court
District Height, MD 20747
baskinm.hehs@gao.gov

Barbara Bates
National Center on Child Abuse and
Neglect
PO Box 1182
Washington, DC 20013
bbates@acf.dhhs.gov

Andrea Battaglia 487
Visiting Nurse Service of New York
In Step Program
154 Beach 84th Street
Rockaway, Queens, NY 11229

Sandra Baxter
U.S. General Accounting Office
Employment and Education
PO Box 75987
Washington, DC 20013

Lula A. Beatty
ADMHA/PHS/DHHS
National Institute on Drug Abuse
Prevention Research
5600 Fishers Lane, Room 10A-08
Rockville, MD 20857-0001

Elizabeth Becker
Research Triangle Institute
PO Box 12194
Research Triangle Park, NC 27709

Bobby Beckham 370
9061 Dewitt Drive
Mechanicsville, VA 23111

Paula J. Beckman 359
University of Maryland
Department of Special Education
College Park, MD 20742
paula_j_beckman@umail.umd.edu

Marjorie Beeghly 581
Harvard Medical School/
Children's Hospital
Child Development Unit
1295 Boylston Street, Suite 320
Boston, MA 02115
beeghly@a1.tch.harvard.edu

Anabel Bejarano 577
30-49 70th Street
Jackson Heights, NY 11370

Jean E. Bell 545
552 Bassetts Bridge Road
Mansfield Center, CT 06250

Sonya Bemporad
The Child Care Group
1221 River Bend Drive, Suite 250
Dallas, TX 75247-4994

Rita K. Benn
3755 Charter Place
Ann Arbor, MI 48105

Margaret S. Benson 269, 270,
272, 273, 587
Penn State University, Altoona
Campus
Department of Psychology
119 Eiche Library
Ivyside Park
Altoona, PA 16601
enz@psu.edu

Michaela Benson 668
Trenton Head Start
222 East State Street, 2nd Floor
Trenton, NJ 08608
kcbkelly@aol.com

John R. Bergan 584
Assessment Technology, Inc.
University of Arizona
5099 East Grant Road, Suite 331
Tucson, AZ 85712

Lisa J. Berlin 306
Teachers College,
Columbia University
Center for Study of Young Children
and Families
PO Box 39
New York, NY 10027-6696
ljb21@columbia.edu

Carol Berman
Zero To Three
National Center for Infants, Toddlers
and Families
734 15th Street, NW, 10th Floor
Washington, DC 20005

Monique C. Better 228, 603
University of Maryland
Institute for Child Study
3304 Benjamin Building
Department of Human Development
College Park, MD 20742
mbetter@wam.umd.edu

Karen Beverly-Ducker
American Speech-Language-
Hearing Association
10801 Rockville Pike
Rockville, MD 20852
kbeverlyducker@asha.org

Mary Jane Bevins
Southwestern Community Action
Council, Inc.
Child and Family Development
Program
540 5th Avenue
Huntington, WV 25701

Cynthia J. Bewick
Tri-County Head Start
755 Hazen
Paw Paw, MI 49079

Merrily C. Beyreuther 57
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Nikolaus Bezruczko 535
1524 East 59th Street
Chicago, IL 60637-2009

C. Raymond Bingham 503
Michigan State University
UM Longitudinal Study
4660 South Hagadorn Road,
Suite 620
East Lansing, MI 48823
10983CRB@msu.edu

Marilyn E. Birchfield 562
Loyola University
Niehoff School of Nursing
1200 Elmwood Avenue
Evanston, IL 60202-1213

William G. Bithoney
Children's Hospital
General Pediatrics
300 Longwood Avenue
Harvard Medical School
Boston, MA 02132

Jan B. Blacher
University of California
School of Education
Riverside, CA 92521-0128

Erika K. Blackburn 654
Cornell University
Department of Human Development
and Family Studies
MVR Hall, G65
Ithaca, NY 14853
ekb2@cornell.edu

Helen Blank 252
Children's Defense Fund
Child Care and Development
25 East Street, NW
Washington, DC 20001-1522

Judith S. Bloch 512
Variety Pre-Schooler's Workshop
47 Humphrey Drive
Syosset, NY 11791-4022

Heather Bloom
National Center for Children in
Poverty
154 Haven Avenue
New York, NY 10032

Donald P. Bolce
278 Springstone Drive
Fremont, CA 94536

B. Lynn Bolen
Southwestern Community Action
Council, Inc.
540 5th Avenue
Huntington, WV 25701-1908

Erika E. Bolig
University of Notre Dame
Department of Psychology
Notre Dame, IN 46556
ebolig@irishma.cc.nd.edu

Kimberly Boiler
NICHD
6100 Executive Boulevard, MSC
7510
Executive Building, Room 4B05
Bethesda, MD 20892-7510
boilerK@hdo1.nichd.nih.gov

Gertha M. Bond 465, 471
E.I.C., Inc. Head Start/NCCU
PO Box 549
712 Virginia Road
Edenton, NC 27932

Barbara L. Bonner
University of Oklahoma Health
Sciences Center
Department of Pediatrics
PO Box 26901
Oklahoma City, OK 73190-0001

Jeanne B. Borger 535
14139 LaSalle
Riverdale, IL 60627

John G. Borkowski
University of Notre Dame
Department of Psychology
Notre Dame, IN 46556

Kelly K. Bost 613
University of North Carolina
Center for Developmental Science
521 South Greensboro Street,
CB#8115
Chapel Hill, NC 27599-8115
kbost@email.unc.edu

Camil Bouchard
U Du Quebec A Montreal
Dept De Psychologie
C.P. 8888 Downtown Station
LAREHS, UQAM
Montreal, Quebec
Canada H3C 3P8
bouchard.camil@uqam.ca

Michele Bourque
Aboriginal Head Start, Health
Canada
Room 2213, Finance Building
Tunney's Pasture, PL 0202C1
Ottawa, Ontario, Canada K1A 1B5

Carol A. Boussy 578
Centers for Disease Control,
NCEH/BDDD
4770 Buford Highway, NE, MS F-15
Atlanta, GA 30341

W Thomas Boyce 348, 349
University of California
Division of
Behavioral/Developmental Pediatrics
400 Parnassus Avenue, Box 0314
San Francisco, CA 94143-0001

Marilyn R. Bradbard 613
Auburn University
Department of Family and Child
Development
203 Spidle Hall
School of Human Sciences
Auburn, AL 36849-5604

Todd Braeger 556
Utah State University
Center for Persons with Disabilities
CPD-6800
Logan, UT 84322-6825

Curtis W. Branch
106 Morningside Drive, #78
New York, NY 10027

Jennifer B. Branch 604
Coldspring Family
Development Center
Head Start Center
4849 Pimlico Road
Baltimore, MD 21215-6040

Ed Brann 578
Center for Disease Control,
NCEH/BDDD
4770 Buford Highway, NE, MS F-15
Atlanta, GA 30341-3724
eab1@cchbddd.em.cdc.gov

Beatty Brasch 551, 673
Lincoln Action Program
1145 High Street
Lincoln, NE 68502

Deborah Breakenridge 281
ABC Head Start Program
14313-92 Avenue
Edmonton, Alberta, Canada T5R
5B3

Sue Bredekamp 427
NAEYC
1509 16th Street, NW
Washington, DC 20036-1426

Margaret Brennan 344, 345
University of North Carolina
Department of MCH-School of
Public Health
Chapel Hill, NC 27599-7400
jktch.sph2@mhs.unc.edu

Grace R. Brilliant 581
Harvard Medical School/Children's
Hospital
Child Development Unit
1295 Boylston Street, Suite 320
Boston, MA 02115

Peter Briss 313
Center for Disease Control
Lead Poisoning Prevention Branch
National Center for
Environmental Health
4770 Buford Highway, MS F-42
Atlanta, GA 30341-3724
pxbs@cehdehl.em.cdc.gov

Robin Brocato 206
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013-1182
rbrocato@acf.dhhs.gov

Laurie Brodersen 563
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345

Gene H. Brody 132, 595
University of Georgia
Department of Child and Family
Development
Dawson Hall, House D
Athens, GA 30602
gbrody@fcs.uga.edu

Martha B. Bronson
Boston College
School of Education
Campion Hall, 201B
Chestnut Hill, MA 02167

Penelope H. Brooks 534
Vanderbilt University
George Peabody College
PO Box 512
Nashville, TN 37203
brooksp@ctrvax.vanderbilt.edu

Jeanne Brooks-Gunn 400
Teachers College, Columbia
University
Center for Children and Families
525 West 120th Street
Box 39
New York, NY 10027-6625
jb224@columbia.edu

Ronda Cobb Brothers
United CAP Head Start
PO Box 384
Pawnee, OK 74058

Bernard Brown
182 New Marx Esplanade
Rockville, MD 20850

Carole W. Brown
JP Kennedy Institute
801 Buchanan Street, NE
Washington, DC 20017

David L. Brown 670
East Texas State University
Department of Education
E. T. Station
Commerce, TX 75429

Eurnestine Brown 439, 623
University of Alabama-Birmingham
Civitan International
Research Center
1719 6th Avenue South
Birmingham, AL 35294-0021
ebrown.civitan@ciemail.circ.
uab.edu

Gwendolyn Y. Brown
Manatee County Head Start
1707 15th Street East
Bradenton, FL 34208-3423

Joshua L. Brown 523, 605
Columbia University School of
Public Health
National Center for Children in
Poverty
154 Haven Avenue
New York, NY 10032
jib42@columbia.edu

Melissa M. Brown 269, 270, 589
SUNY-College at Brockport
Department of Psychology
350 New Campus Drive
Brockport, NY 14420
mbrown@acspr1.acs.brockport.edu

Robert E. Brown 89, 546
United Way of Michigan
300 North Washington, #405
PO Box 18219
Lansing, MI 48901-8219

Treeby Brown
Association of Maternal and Child
Health Programs
1350 Connecticut Avenue, NW
#803
Washington, DC 20036
treeby@amchp.org

Dorothy C. Browne
University of North Carolina
Maternal and Child Health
400 Rosenau Hall
Campus Box 7400
Chapel Hill, NC 27599-7400

Kimberly G. Browning 538
University of Michigan
School of Education
Ann Arbor, MI 48109
kbrowning@prodigy.com

Sheila L. Broyles 516
UCSD
Community Pediatrics
9500 Gilma Drive
Department 0927
La Jolla, CA 92093-0927

Mary Beth Bruder 506
University of Connecticut
Health Center
Division of Child and Family Studies
309 Farmington Avenue
Suite A-200, Farm Hollow
Farmington, CT 06032
bruder@sun.uhc.edu

Gail Brummitt 530
Wayne State University
Merril-Palmer Institute
71-A East Ferry Street
Detroit, MI 48202

Lorelei R. Brush 495
Pelavin Research Institute
1000 Thomas Jefferson Street, NW
Suite 400
Washington, DC 20007
lbrush@air_dc.org

Beverly Bryant 465, 466
North Carolina Central University
Department of Human Sciences
1801 Fayetteville Street
Durham, NC 27707

Donna M. Bryant 106, 127, 129,
242, 289, 290, 546
University of North Carolina at
Chapel Hill
Frank Porter Graham Child
Development Center
Family and Child Care Research
Program
105 Smith Level Road, CB 8180
Chapel Hill, NC 27599-8180
bryant.fpg@mhs.unc.edu

Richard Budget
Aboriginal Head Start, Health
Canada
Room 2216, Finance Building
Jodney's Pasture, 0202C1
Ottawa, Ontario, Canada K1A 1B5

Louis Buffardi 557
George Mason University
Psychology Department
Fairfax, VA 22030
buffardi@gmu.edu

Charlotte E. Burchard 347, 350
3524 22nd Street
San Francisco, CA 94114-3406
char456@aol.com

Margaret R. Burchinal 574, 609
University of North Carolina at
Chapel Hill
Frank Porter Graham Child
Development Center
105 Smith Level Road, CB 8180
Chapel Hill, NC 27599-8180
burchina.fpg@mhs.unc.edu

Melissa Burke 359
Mid-Cumberland CAA
219 South Maney Avenue
Murfreesboro, TN

Sharon Burke 580
Queen's University
School of Nursing
90 Barrie Street
Kingston, Ontario, Canada K7L 3N6

Elizabeth Burki 551, 559, 560
Detroit Health Department
Detroit-Skillman Parenting Program
1151 Taylor Building 4, Room 110
Detroit, MI 48202

Lynne Burnett
Coalition of Rural Representatives
from Breton/Buck Creek
Box 779
Breton, Alberta, Canada T0C 0P0

M Susan Burns 506
The National Research Council
National Academy of Sciences
2101 Constitution Avenue, NW
HA 178
Washington, DC 20418
sburns@nas.edu

Rosemary Burton 600
George Mason University
Department of Psychology
4400 University Drive
MS 3F5
Fairfax, VA 22030-4444

Leah T. Buscemi
309 11th Avenue
Sterling, IL 61081

Katharine G. Butler
10551 Hidden Mesa Place
Monterey, CA 93940-6628

Suellen G. Butler 597
222 Garrett Avenue
Swarthmore, PA 19081-1432

Peggy Butler-Ainsworth 549
P.A.C.E. Head Start
710 Katie Avenue
Hattiesburg, MS 39401

Olga Bzdyk
Le Jardin Head Start
Head Start/CDS
51 West Mowry Drive
Homestead, FL 33030

Howard Cabral 581
Boston University School of
Medicine
Department of Biostatistics
School of Public Health
Boston, MA 02118

Connie Cabrera 132, 144, 148
904 Pamela Drive
Mission, TX 78572

Natasha Cabrera
National Academy of Sciences
Board on Children and Families
2101 Constitution Avenue, NW
Harris Building
Washington, DC 20418-0007
NCabrera@NAS.EDU

Thomas A. Caffrey
1841 Broadway, Room 702
New York, NY 10023

Bettye M. Caldwell 253
Arkansas Children's Hospital
Department of Pediatrics/CARE
800 Marshall Street
Little Rock, AR 72202-3510
bettyemd@care.ach.uams.edu

Greg Camilli 406
Rutgers University
Graduate School of Education
10 Seminary Place
New Brunswick, NJ 08903
camilli@rci.rutgers.edu

Elizabeth K. Campbell 563
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345
campb043@maroon.tc.umn.edu

Frances A. Campbell 581
University of North Carolina -
Chapel Hill
Frank Porter Graham Child
Development Center
105 Smith Level Road
Campus Box 8180
Chapel Hill, NC 27599-8180
campbell.fpg@mhs.unc.edu

Mary M. Campbell
American Psychological Association
Children, Youth and Families Office
750 1st Street, NE
Washington, DC 20002-4241

Ed Canda 404
University of Kansas
3603 Boulder Street
Lawrence, KS 66049

Sally Schwer Canning 640
Wheaton College
Psychology Department
501 College Avenue
Wheaton, IL 60187
scanning@david.wheaton.edu

Elise Cappella 566
Children's Television Workshop
1 Lincoln Plaza
New York, NY 10023
elise.cappella@ctw.org

Gilberto Cardenas 400
University of Texas
Center for Mexican-American
Studies
IUPLR
PO Box 8180
Austin, TX 78713-8180
gilberto@mail.utexas.edu

Jacqueline Carey
University of Maryland
Eastern Shore
Department of Human Ecology
Richard Henson Center
Prince Ann, MD 21853-1299
jcarey@umes-bird.umd.edu

Liza D. Cariaga-Lo 611
Wake Forest University
Bowman Gray School of Medicine
Office of Educational Research
Winston-Salem, NC 27157
cariaga@phs.bgsu.wfu.edu

Frank A. Carino
Administration for Children and
Families
26 Federal Plaza
New York, NY 10278

Mark Carlson
Northwest Community Action, Inc.
208 North Main Street, Box 67
Badger, MN 56714
mcarlson@badger.polaris.net

Nancy A. Carlson 514
LaRabide-University of Chicago
Research and Policy Center
950 East 61st Street
Chicago, IL 60637
nc12@midway.uchicago.edu

Judith J. Carta 214, 311, 402
University of Kansas
Kansas E. C. Research Institute
Juniper Gardens Children's Project
1614 Washington Boulevard
Kansas City, KS 66102
carta@kuhub.cc.ukans.edu

David A. Caruso 643
University of Rhode Island
Department of Human Development
and Family Studies
10 Lower College Road
Kingston, RI 02881

Neil Rogers Carvell 594
Southern Methodist University
Learning Therapist Program
PO Box 750384
Dallas, TX 75275-0384
ncarvell@mail.smu.edu

Betty Cassidy 265
National Association for Family
Child Care
c/o 1630 Winthrop Drive
Newport News, VA 23602

William A. Castellanos
EOC of San Luis Obispo
County, Inc.
Department of Child, Youth and
Family Services
1030 Southwood Drive
San Luis Obispo, CA 93401

Sharon Castillo
AVANCE San Antonio, Inc.
2300 West Commerce, Suite 304
San Antonio, TX 78207

Margaret O'Brien Caughy 640
Johns Hopkins University
Department of Maternal and Child
Health
624 North Broadway
Baltimore, MD 21205-1901
mcaughy@phnet.sph.jhu.edu

Meredith Censullo
PO Box 1178
Sandwich, MA 02563-1178

Gabriel Cervera
AVANCE San Antonio, Inc.
2300 West Commerce, Suite 304
San Antonio, TX 78207

Mary Anne Chalkley 127, 131
University of St. Thomas
Department of Psychology
2115 Summit Avenue
Mail No 4145
Saint Paul, MN 55105-1048
machalkley@stthomas.edu

Bernard Challenor
Columbia University School of
Public Health
HPM
600 West 168th Street, 6th Floor
Room 617
New York, NY 10032

Albert Chang 344
San Diego State University
Graduate School of Public Health
Division of Maternal and Child
Health
5500 Campanile Drive
San Diego, CA 92182-4162
albert.chang@sdsu.edu

Nina Chaudry 523, 605
Columbia University School of
Public Health
National Center for Children in
Poverty
154 Haven Avenue
New York, NY 10032
nc46@columbia.edu

Margaret Chesney 348, 349
University of California at San
Francisco
Center for Prevention Sciences
Group
74 New Montgomery Street,
Suite 600
San Francisco, CA 94105

Lisa Chase Childers 537
St. Luke's School
487 Hudson Street
New York, NY 10014

Stephanie Childs 644
South Philadelphia High School
Philadelphia Head Start Learning
Center
Broad and Snyder Avenue,
Room 203
Philadelphia, PA 19148

Kate Christian 490
Loyola University Chicago
6525 North Sheridan Road
Damen Hall, 631
Chicago, IL 60626
kchrist@luc.edu

Robert E. Chubrich 528
2348 East LaJolla
Tempe, AZ 85282

Susan L. Churchill 127, 132
University of Georgia
Department of Child and Family
Development
Dawson Hall
Athens, GA 30602
schurchill@fcs.uga.edu

Kerry L. Cielinski 613
Auburn University
Family and Child Development
203 Spidle Hall
Auburn, AL 36849-5604

Susan Clampet-Lundquist 606
312 West Seymour Street
Philadelphia, PA 19144
v2230g@vm.temple.edu

Roseanne Clark
University of Wisconsin
Medical School
Department of Psychiatry
600 Highland Avenue
Madison, WI 53792-0001

Sandra Clark 408
The Urban Institute
2100 M Street, NW
Washington, DC 20037
sclark@ui.urban.org

Carole L. Clarke 149
Center for Education and Manpower
Resources
Migrant Head Start
410 Jones Street, Suite C
Ukiah, CA 95482-2770

Jerry Cline 669
Virginia Polytechnic Institute and
State University
Northern Virginia Graduate Center
2990 Telestar Court
Falls Church, VA 22042

Marvin G. Cline
3513 Sundown Farms Way
Olney, MD 20832
mccline@vatech.edu

Holly A. Cloonan 601
West Virginia University School of
Medicine
Department of Behavioral Medicine
and Psychiatry
PO Box 1547
Charleston, WV 25326-1547

Nicole C. Close 206
The CDM Group
5530 Wisconsin Avenue, Suite
1660
Chevy Chase, MD 20815

Robert B. Clyman
Children's National Medical Center
Department of Psychology
111 Michigan Avenue, NW
Washington, DC 20010-2970
rclyman@gwis2.circ.gwu.edu

Ladora A. Cobb
Administration on Children, Youth
and Families
Head Start Bureau/Region XI
PO Box 1182
Washington, DC 20013

Moncrieff Cochran 592, 629, 641
Cornell University
Department of Human Development
and Family Studies
Cornell Early Childhood Program
HDHS: G 35, Martha Van
Rensselaer Hall
Ithaca, NY 14850
mmc6@cornell.edu

Kip Coggins 631
University of Texas at El Paso
Department of Social Work
El Paso, TX 79912

George Cohen 604
Center for Infant Study
408 West Lombard Street
Baltimore, MD 21201
gcohen@ummary.ab.umd.edu

Joyce H. Colbert
Title I
24617 Lunsford Court
Damascus, MD 20872

Karen K. Colbert 636
Iowa State University
Department of Human Development
and Family Studies
101 Child Development Building
Ames, IA 50011-1030

Michele B. Cole
Advocates for Youth
1025 Vermont Avenue, NW,
Suite 200
Washington, DC 20005

Robert Cole 570
University of Rochester
Medical Center
601 Elmwood Avenue
Box Psych
Rochester, NY 14642
cole@son.rochester.edu

Laura J. Colker 646
L.J. Colker and Associates
1260 21st Street, NW
Suite 611
Washington, DC 20036-2370
ljcolker@aol.com

Francine Y. Collins 106
Cambridge Head Start
221 Hampshire Street
Cambridge, MA 02139

Traci L. Colvin 514
La Rabida-University of Chicago
Research and Policy Center
950 East 61st Street, Room 268
Chicago, IL 60637

Ann Condon
AVANCE San Antonio, Inc.
2300 West Commerce, Suite 304
San Antonio, TX 78207

David C. Connell 206
Abt Associates
55 Wheeler Street
Cambridge, MA 02138-1168
dave_connell@abt.assoc.com

David B. Conner 642
Truman State University
Department of Psychology
Kirksville, MO 63501
ss33@nemomus.bitnet

Kathleen Coolahan 147, 598, 644
University of Pennsylvania
Graduate School of Education
Psychology in Education Division
3700 Walnut Street
Philadelphia, PA 19104
kcool@dolphin.upenn.edu

Catherine Cooper 389
University of Santa Cruz
Board of Studies in Psychology
Kerr Hall
Santa Cruz, CA 95064

Susan G. Cooper 634
Southeastern Louisiana University
Family Studies and Educational
Leadership
SLU 341
Hammond, LA 70402
scooper@selu.edu

John P. Corrigan
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013
jcorrigan@acf.dhhs.gov

Carmen P. Cortez 400
Avance Hasbro National Family
Resource Center
Avance Family Support and
Education Program
301 South Frio Street, Suite 310
San Antonio, TX 78207-4421

Joyce R. Cosby
Richmond Public Schools
Head Start
301 North 9th Street, 12th Floor
Richmond, VA 23219

Joan Costello
211 Elm Street
Glenview, IL 60025

Melva T. Covington 576
Emory University
Rollins School of Public Health
Center for Public Health Practice
Atlanta, GA 30333
covington@fox.sph.emory.edu

Catherine Cowell 346
Columbia University School of
Public Health
CPFH
60 Haven Avenue, B-3
New York, NY 10032

Senobia D. Crawford 102, 105
Administration on Children, Youth
and Families
Research, Demonstration, and
Evaluation Branch
330 C Street, SW
Mary Switzer Building
Washington, DC 20201
scrawford@acf.dhhs.gov

Vanella Crawford 102, 105
Community Advisory Board
1109 Michigan Avenue, NE
Washington, DC 20017

Maria A. Crisafi
45 Terrace Drive
Nyack, NY 10960-4219

Dwayne A. Crompton 214
KCMC Child Development
Corporation
Administration
2014 East 18th Street
Kansas City, MO 64127

Deanne A. Crone 538
SUNY at Stonybrook
Department of Psychology
Stony Brook, NY 11794-2500
russgrd2@psych1.psy.sunysb.edu

Myra Crouch-Robinson
Child Development Council-Franklin
County
398 South Grant Avenue, Suite 205
Columbus, OH 43215-5549

Judith A. Crowell 421
SUNY at Stony Brook
Department of
Psychiatry/Psychology
Stony Brook, NY 11794

Roman Cruz
Texas Migrant Council, Inc.
5102 North Bartlette Avenue
Laredo, TX 78041

Gayle Cunningham 106, 427
Jefferson County Commission for
Economic Opportunity
Head Start
300 8th Avenue West
Birmingham, AL 35204
gcjceo@aol.com

Nicholas Cunningham
Columbia University
Pediatrics and Public Health
Vanderbilt Clinic H4-402
622 West 168th Street
New York, NY 10032

Larry Curly 584
Assessment Technology, Inc.
5099 East Grant Road, Suite 331
Tucson, AZ 85712

Robert Curran 589
SUNY - Brockport
Department of Psychology
350 New Campus Drive
Brockport, NY 14420

Miranda D'Amico 468
Concordia University
Department of Education
1455 de Maisonneuve Ouest
Montreal, Quebec,
Canada H3G 1M8

Linda L. Dannison 632
Western Michigan University
Family and Consumer Sciences
3018 Korman Hall
Kalamazoo, MI 49008-5067
dannison@wmich.edu

William A. Darity, Jr.
University of North Carolina
Department of Economics
Gardner Hall
Campus Box 3305
Chapel Hill, NC 27599-0001

Deborah A. Daro 423
National Committee to Prevent Child
Abuse
National Center on Child Abuse
Prevention Research
332 West Michigan Avenue,
Suite 1600
Chicago, IL 60604-4357

Lois-Ellin G. Datta
Delta Analysis
PO Box 363768
Waikoloa, HI 96738-3768

Andrew Davidson
Columbia University School of
Public Health
CPFH
60 Haven Avenue, B-2
New York, NY 10032

Gwendolyn Davis
University of Pennsylvania
Graduate School of Education
Psychology in Education Division
3700 Walnut Street
Philadelphia, PA 19104-6216
davisgy@dolphin.upenn.edu

Michelle de Haan 620
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345
mdehaan@vx.cis.umn.edu

Elizabeth K. DeMulder 502
George Mason University
Psychology Department
Mailstop 3F5
Fairfax, VA 22030-4444
edemulde@osf1.gmu.edu

Ebenezer A. F. de Oliveira 499
University of Delaware
202 Willard Hall
Newark, DE 19716-2920
ebe@brahms.udel.edu

James P. DeSantis 550
CSR, Inc.
1400 Eye Street, NW, #200
Washington, DC 20005
jimpdes@aol.com

Jane DeWeerd 359
7 East Cliff Street
Alexandria, VA 22301

Sharon G. Deich 495
Pelavin Research Institute
1000 Thomas Jefferson Street, NW
Washington, DC 20007
sdeich@air-dc.org

Susanne A. Denham 502, 600
George Mason University
Department of Psychology
4400 University Drive
MS 3F5
Fairfax, VA 22030-4444
sdenham@vms1.gmu.edu

Karl W. Dennis 423
Kaleidoscope Satellite Family
Outreach Program
1279 North Milwaukee Avenue,
#250
Chicago, IL 60622

Kristin L. Denton 626
University of Maryland
Institute for Child Study
3304 Benjamin Building
College Park, MD 20742

Linda E. Derscheid 529
Northern Illinois University
Department of Human and Family
Resources
209 Wirtz, HFR Department
DeKalb, IL 60115-2854

Larry W. Desch
5142 Door Drive
Madison, WI 53705

Karen E. Diamond 507
Purdue University
Department of Child Development
and Family Studies
1267 CDFS Building
W. Lafayette, IN 47907-1267
kdiamond@vm.cc.purdue.edu

Linda Diamond 568
George Washington University
Medical Center
23rd and I Street, NW, Room 222
Washington, DC 20037

Laura Diaz 633
University of Denver
Department of Psychology
2155 South Race Street
Frontier Hall
Denver, CO 80208
ldiaz@pstar.psy.du.edu

David K. Dickinson 106, 127
Education Development Center
55 Chapel Street
Newton, MA 02158-1060
ddickinson@edc.org

Lynda J. Dickinson 643
Child, Inc.
Head Start Program
1642 West Shore Road
Warwick, RI 02889

David C. Diehl 592
Cornell University
HDFS
MVR Hall
Ithaca, NY 14850
dd13@cornell.edu

Celestine Y. Diggs-Smith 233
District of Columbia Public Schools
Drew Elementary School
Head Start Program
56th and Eads Street, NW
4th Floor
Washington, DC 20019

Judith Dighe
Head Start Montgomery County
Public Schools
4910 Macon Road
Rockville, MD 20852

Laura L. Dittmann
University of Maryland
10709 Clermont Avenue
PO Box 66
Garrett Park, MD 20896-0066

Pia Divine
Administration on Children, Youth
and Families
Child Care Bureau
200 Independence Avenue, SW
Room 329, F Humphrey Building
Washington, DC 20201-0004
Pdivine@acf.dhhs.gov

Henry Doan 197
Administration on Children, Youth
and Families
330 C Street, SW
Switzer Building, Room 2411
Washington, DC 20201
hedoan@acf.dhhs.gov

Dionne R. Dobbins 583
University of Miami
Department of Psychology
PO Box 249229
Psychology Annex
Coral Gables, FL 33124-0721
ddobbins@child.psy.miami.edu

Anne M. Doerr
Lycorning/Clinton Head Start
Pennsylvania Head
Start/Administrators Association
2138 Lincoln Street
PO Box 3568
Williamsport, PA 17701-5549

Arny Dombro
120 Cabrini Boulevard,
Apartment 29
New York, NY 10033-3429
adombro@village.os.com

Audley Donaldson 104
North Hartford Family Resource
Center
Martin Luther King School
25 Ridgefield Street
Hartford, CT 06112

Carolyn S. Dorrell 646
Early Childhood Professional
Development Network
2712 Millwood Avenue
Columbia, SC 29205-1221

Sherri Doughty
U.S. General Accounting Office
GAO/HEHS
NGB/Education and Employment
441 G Street, NW
Washington, DC 20024
doughtys.hehs@gao.gov

Charlene Douglas 557
George Mason University
Nursing Department
C304 Carroll Hall
Fairfax, VA 22030
cdouglas@gmu.edu

Mary Dozier 604, 662
University of Delaware
Department of Psychology
Newark, DE 19716-2755
mdozier@udel.edu

Jane Drapeaux 674
SD Transition Project
PO Box 687
3rd and Broadway
Yankton, SD 57078-0687

Shelley Drazen 588
Binghamton University
Psychology Department
PO Box 6000
Binghamton, NY 13902-6000
sdrazen@binghamton.edu

Nicole M. Driebe 629
117 Oak Avenue, #6
Ithaca, NY 14850
nmd1@cornell.edu

Jane Drummond 281
University of Alberta
Faculty of Nursing
3rd Floor, Clinical Sciences Building
Edmonton, Alberta,
Canada T6G 2G3
jdrummon@ua-nursing-ualberta.ca

Gail Duane
University of Minnesota
Project Impact/Optum
909 Social Science Building
Minneapolis, MN 55440

Judith Semon Dubas 370, 373
College of William and Mary
Department of Psychology
PO Box 8795
Williamsburg, VA 23187-8795
wpspsj@wmmva.cc.wm.edu

Pat Dubus 293
The Better Homes Foundation
181 Wells Avenue
Newton Centre, MA 02159

Vincent Dufort 345
University of North Carolina
Maternal and Child Health
Department
Chapel Hill, NC 27599

Loraine Dunn 636
University of Oklahoma
Instructional Leadership
820 Van Fleet Oval
Collings Hall, Room 114
Norman, OK 73019-0260
aldunn@uoknor.edu

Carol S. Dweck 625
Columbia University
Department of Psychology
1190 Amsterdam Avenue
New York, NY 10027
dweck@paradox.psych.
columbia.edu

Felton J. Earls 216
Harvard School of Public Health
677 Huntington Avenue
Boston, MA 02115-5794

Janet Eatman
University of Illinois
Department of Human and
Community Development
905 South Goodwin Avenue
174 Bevier Hall
Urbana, IL 61801

Jacquelynne S. Eccles 374, 389
University of Michigan
610 East University
1416 School of Education Building
Ann Arbor, MI 48109-1259
jeccles@umich.edu

Karen Eckert 535
11258 S. Washtenaw
Chicago, IL 60655

Deborah A. Edward 615
Austin Children's Museum
1501 West 5th Street
Austin, TX 78703

Patricia A. Edwards
Michigan State University
Department of Teacher Education
308 Erickson Hall
East Lansing, MI 48824-1034

Byron R. Egeland 275 279
University of Minnesota
Child Psychology
51 River Road
230 Child Development
Minneapolis, MN 55455

Harriet A. Egertson
Nebraska Department of Education
Office of Child Development
301 Centennial Mall South
Lincoln, NE 68508-2529
egertson@nde4.nde.state.ne.us

Carole Eiben
Administration on Children, Youth
and Families
Washington, DC 20201

Ayman El-Mohandes 102, 105,
640
George Washington University
Hospital Medical Center
Department of Newborn Service
901 23rd Street, NW
Room 3246-S
Washington, DC 20037
mohandes@cgwis2.circ.gwu.edu

Veronica Elliot 563
Birch and Davis Associates, Inc.
Health Policy Group
8905 Fairview Road, Suite 200
Silver Spring, MD 20910
velliott@bdhealthpol.com

Dawn C. Ellis 520
ASHA
10801 Rockville Pike
Rockville, MD 20852
dellis@asha.org

Robert N. Emde 309
University of Colorado Health
Science Center
School of Medicine
Department of Psychiatry
4200 East 9th Avenue,
Box C268-69
Denver, CO 80262
bob.emde@uchsc.edu

Jonathan C. Engel 558
Community Action, Inc. Head Start
Program
Office of Community Development
PO Box 1246
San Marcos, TX 78667
jonengel@touch.net

Doris R. Entwisle
Johns Hopkins University
Department of Sociology
541 Mergenthaler Hall
Baltimore, MD 21218

Willie J. Epps 43, 89, 465
Southern Illinois University
East St. Louis Center
411 East Broadway
East St. Louis, IL 62201

Joyce L. Epstein
Johns Hopkins University
Families, Communities, Schools and
Children's Learning Center
3505 North Charles Street
Baltimore, MD 21218-2404

Michael Epstein 423, 424
Northern Illinois University
Department of Educational
Psychology
Graham Hall
Excellence in Education
DeKalb, IL 60115

Carol Erdwins 557
George Mason University
Psychology Department
Fairfax, VA 22030
cerdwins@gmu.edu

Linda Espinosa
6396 South Sabine Drive
Columbia, MO 65203
educle@mizzou1.missouri.edu

Ruth Etzel 313
National Center for
Environmental Health
Centers for Disease Control and
Prevention
4770 Buford Highway
MSF - 39
Atlanta, GA 30341-3724

David Evans
Columbia University
Pediatric Pulmonary Division
630 West 168th Street
Room BHN-807
New York, NY 10032

Bonnie J. Faddis 186
RMC Research Corporation
522 SW 5th Avenue, Suite 1407
Portland, OR 97204
bonnie_faddis@rmccorp.com

Jay S. Fagan
8300 Brookside Road
Elkins Park, PA 19027

Richard A. Faldowski
Medical University of South
Carolina-Psychiatry
171 Ashley Avenue, Annex III
Charleston, SC 29425-0742
faldowra@musc.edu

Shi-Ruei S. Fang 529
Northern Illinois University
Department of Human
and Family Resources
1816 North First Street
DeKalb, IL 60115
ssfang@niu.edu

John W. Fantuzzo 144, 147, 598,
616, 640, 644
University of Pennsylvania
Graduate School of Education
3700 Walnut Street, Suite D-34
Philadelphia, PA 19104-6216
johnf@nwfs.gse.upenn.edu

Dale C. Farran
University of North Carolina at
Greensboro
Child Development and Family
Studies
C-5 Park Building
Greensboro, NC 27412

Dana Fay 604
Center for Infant Study
408 West Lombard Street
Baltimore, MD 21201

Edith Fein 293
Dunne, Kimmel and Fein, Inc.
31 Pocahontas Drive
West Hartford, CT 06117

Carolyn M. Feisal
Administration on Children, Youth
and Families
Child Care Bureau
200 Independence Avenue, SW
Room 320-F
Washington, DC 20912

Jason K. Feld 584
ATI Center for Child Development
University of Arizona
5099 East Grant Road, Suite 331
Tucson, AZ 85712-2764

Lillian M. Feldman
704 Crawford Avenue
Syracuse, NY 13224-1926

Nancy Feldman 336
UCare Minnesota
UAFF
2550 University Avenue West
Suite 201S
St. Paul, MN 55114

Karrie Ferguson 599
Pacific Lutheran University
Marriage and Family Therapy
Program
East Campus
Tacoma, WA 98447

S. Alease Ferguson 532, 554
The Center for Families and
Children
1468 West 9th Street
Western Reserve Building
Cleveland, OH 44113

Jolene B. Ferro 510
University of Southern Florida/
Head Start
Florida Mental Health Institute
13301 Bruce B Downs Boulevard
Tampa, FL 33612-3807
ferro@hal.usf.edu

Rebecca R. Fewell 608
University of Miami
School of Medicine
The Debbie Institute
PO Box 014621
Miami, FL 33101
rfewell@peds.med.miami.edu

John Fieberg 344, 345
University of North Carolina
Department of MCH-School of
Public Health
Chapel Hill, NC 27599-7400
jkotch.sph2@mhs.unc.edu

William S. Fillmore, Jr. 427
Pinellas County Head Start
Child Development and Family
Services Head Start
6698 68th Avenue North, Suite D
Pinellas Park, FL 34665

Mark A. Fine
University of Missouri at Columbia
Department of Human Development
and Family Services
32 Stanley Hall
Columbia, MO 65211-0001
hdfine@mizzou1.missouri.edu

Charlene Firestone 102, 103, 551
Wayne State University
Center for Urban Studies/Urban
Families Program
656 West Kirby
Faculty Administration Building,
Room 3265
Detroit, MI 48202
cfirest@cms.cc.wayne.edu

Janet E. Fischel
State University of New York at
Stony Brook
Department of Pediatrics
Health Science Center, T11,
Room 020
Stony Brook, NY 11794-8111
jfischel@epo.som.sunysb.edu

Margaret Fish 573
Marshall University School of
Medicine
Department of Family and
Commission Health
Huntington, WV 25755-9420
fishm@mumvs6.mu.wvnet.edu

Hiram E. Fitzgerald 43, 89, 503,
548
ADS at Michigan State University
1-2 Kellogg Center
East Lansing, MI 48824-1022
10983hef@msu.edu

Michael J. Flahive
Saint Xavier University
Communications Sciences and
Disorders
3700 West 103rd Street
Chicago, IL 60655

Sally Flanzer
National Center on Child Abuse and
Neglect
PO Box 1182
Washington, DC 20013-1182
sflanzer@acf.dhhs.gov

Alfredo R. Flores
Texas Tech University
Institute for Child and Family
Studies
PO Box 4170
Lubbock, TX 79409

Daniel A. Flynn
Los Angeles County Office of
Education-Head Start
17315 Studebaker Road
Cerritos, CA 90701

Mary L. Flyr 615
University of California-Riverside
Psychology Department-075
Riverside, CA 92521

Rosalind Folman 293
225 Coolidge Avenue,
Apartment 108
Watertown, MA 02172
cdse@umbusky.cc.umb.edu

Rowena Fong
University of Hawaii - Manoa
School of Social Work
2500 Campus Road
Hawaii Hall 231
Honolulu, HI 96822

Sandy Foreman 163
Southwest Human
Development, Inc.
202 East Earl Drive
Suite 140
Phoenix, AZ 85012-2634

Molly Forman
Library of Congress/Congressional
Research Service
CRS-EPW
LM320/7440
Washington, DC 20540-7440
mforman@crs.loc.gov

Sandra Scott Forrest
Fairfax County Office for Children
3701 Pender Drive, 5th Floor
Fairfax, VA 22030-6045

E. Michael Foster
Vanderbilt University
1207 18th Avenue South
Nashville, TN 37212
foster@uansv5.vanderbilt.edu

William Fowler
Center for Early Learning and Child
Care, Inc.
29 Buckingham Street
Cambridge, MA 02138
fowler@user1.channel1.com

Lise Fox 510
University of South Florida
Florida Mental Health Institute
13301 Bruce B Downs Boulevard
Tampa, FL 33612-3899

Nancy Fox 496
Interface Neighbors
247 East 82nd Street
New York, NY 10028

Maria P. Fracasso 522
Towson State University
Psychology Department
Towson, MD 21204
e7p4fra@toe.towson.edu

Ann J. Francis 102
Virginia Polytechnic Institute and
State University
Virginia Tech Resource and
Referral Service
404 Clay Street
Blacksburg, VA 24061-0416
francisa@vtvm1.cc.vt.edu

Deborah A. Frank 581
Boston City Hospital
Department of Pediatrics
FGH-3
Boston, MA 02118

Nancy Frank
Research Triangle Institute
PO Box 12194
Research Triangle Park, NC 27709

Arthur J. Frankel
Yeshiva University
Wurzweiler School of Social Work
2495 Amsterdam Avenue
Belfer Hall
New York, NY 10033

Gwen M. Freeman
1667 Valencia Way
Reston, VA 22090

Lucia French 539
University of Rochester
Warner Graduate School of
Education and Human Development
Rochester, NY 14627

Maxine Freund
The George Washington University
2134 G Street, NW, #416
Washington, DC 20052

Paul J. Frick
The University of Alabama
Department of Psychology
PO Box 870348
Tuscaloosa, AL 35487-0348

Janice L. Friedman
Variety Pre-Schooler's Workshop
Warner Graduate School of
Education and Development
47 Humphrey Drive
Rochester, NY 11791-4022

Inez C. Friedman-Lipetz
United Cerebral Palsy Association
816 Cardinal Lane
Huntington Valley, PA 19006

Victoria R. Fu 102
Virginia Polytechnic Institute and
State University
Department of Family and Child
Development
309 Wallace Hall
Blacksburg, VA 24061-0416
vfu@vt.edu

Carolee Fucigna 492
Wellesley College
Center for Research on Women
Wellesley, MA 02181
cfucigna@wellesley.edu

Mary Fulbright 43, 89
University of Texas at Arlington
Community Services Development
Center
Box 19129
Arlington, TX 76019-0129

Bruce Fuller
Harvard University
Graduate School of Education
450 Gutman
6 Applan Way
Cambridge, MA 02138-3704

Sara E. Gable 624
University of Missouri-Columbia
Department of Psychology
200 South 7th Street
132 Psychology Building
Columbia, MO 65211
psychsg@mizzou1.missouri.edu

Yael Gabrieli 488
Israel Ministry of Education
Department of Parent and
Community Programs
Early Childhood Division
39 Shaul HaMelech Boulevard
Tel Aviv, Israel

Jim A. Gage
Southern UTE Tribe, SUCAP, Inc.
PO Box 400
Ignacio, CO 81137-0400

Joseph Galano 370, 373
College of William and Mary
Department of Psychology
PO Box 8795
Williamsburg, VA 23187-8795
jgalano@facstaff.wm.edu

Anastasia Galanopoulos 494
136 Kimport Avenue
Boalsburg, PA 16827-1230
anastasia@pop.psu.edu

Ellen Galinsky 265
Families and Work Institute
330 7th Avenue, 14th Floor
New York, NY 10001
emgalinsky@aol.com

Terri M. Gallmeier
6316 South Ironton Court
Englewood, CO 80111

Alice R. Galper 626
University of Maryland
Mount Vernon College
3304 Benjamin Building
College Park, MD 20742

Sandra K. Gant 465, 469
First Baptist Church Head Start
518 Jefferies Street
Burlington, NC 27217
sgant@headstart.com

Cynthia Garcia-Coll 374, 389
Brown University
Education Department
PO Box 1938
Providence, RI 02912-1938
cgc@brownvm.brown.edu

Aurora Garcia-Tunon
New York University
Resource Access Project
(Region II)
Department of Teaching and
Learning
239 Greene Street, Room 200
New York, NY 10003

Ann Garwick 513
University of Minnesota/Medical
School
Division of General Pediatrics
Adolescent Health Medical School,
Box 721
420 Delaware Street, SE
Minneapolis, MN 55455

Jeanette M. Gassaway
Michigan State University
Department of Psychology
East Lansing, MI 48824
jeanette.gassaway@ssc.msu

Marianna Gaston 228
Resolving Conflict Creatively
Program
Board of Education,
City of New York
163 3rd Avenue, #239
New York, NY 10003
rccpny@gramercy.ios.com

Janet Gebelt 668
Rutgers University
Center for Social and Community
Development
Livingston Campus
Building 4086, Room 139
Piscataway, NJ 08855
gebelt@gandalf.rutgers.edu

Kathryn Geismar 543
Harvard University Graduate School
of Education
Human Development and
Psychology
Appian Way
Cambridge, MA 02138

Susan Rose Geller 370, 371
Virginia Commonwealth University
Virginia Institute for Developmental
Disabilities
PO Box 843020
Richmond, VA 23284-3020
sgeller@cabell.vcu.edu

Janice L. Genevro 347, 348, 349
NICHD
Child and Family Research Section
9000 Rockville Pike
Building 31, Room 82B15
Bethesda, MD 20892-0001
jgl@cu.nih.gov

Gwyn George 370
194 Quarter Trail
Newport News, VA 23608

Nancy M. Gerard 632
Andrews University
Behavior Sciences Department
Berrien Springs, MI 49103
gerardn@andrews.edu

Gabrielle Gerhard 496
2 Washington Square Village,
Apartment 13K
New York, NY 10012-1709
ggg6065@is.nyu.edu

Suzanne G. Gerlach-Downie 289,
290
SRI International
Health and Social Policy Division
333 Ravenswood Avenue
Menlo Park, CA 94024-3493
suzltd@unix.sri.com

Clara A. Giambruno 346
279 East 44th Street, Apartment
20D
New York, NY 10017

Lorraine Gianvecchio 539
University of Rochester
Warner Graduate School
Rochester, NY 14627

Cindy Gibbons
Michigan State University
1432 Harvard Road
East Lansing, MI 48823

Alicia Gilbert 654
University of California-Riverside
Department of Psychology-075
c/o UCR Social Development
Project
Riverside, CA 92521

Rita Giles 669
Virginia Polytechnic Institute and
State University
Northern Virginia Graduate Center
2990 Telestar Court
Falls Church, VA 22042

Herbert P. Ginsburg
Columbia University
Teachers College
Department of Development and
Educational Psychology
Box 184
New York, NY 10027

Benjamin Gitterman 313
Children's National Pediatric
Association
111 Michigan Avenue, NW
Washington, DC 20010

Robert Glenn
U.S. Department of Education
600 Independence Avenue, SW
Room 4152, FOB10-B
Washington, DC 20202
robert_glenn@ed.gov

Michelle P. Glick 608
University of Miami
Debbie School
PO Box 014621
Miami, FL 33101

Denise Glover
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Julianna Golas 643
University of Rhode Island
Department of Human Development
and Family Studies
10 Lower College Road
Kingston, RI 02881
jgol3103@uriacc.uri.edu

Susan F. Gold
University of Miami
Department of Pediatrics
Mailman Center for Child
Development
1601 NW 12th Avenue
Miami, FL 33136
sgold@mednet.med.miami.edu

Olivia A. Golden 16
Administration on Children, Youth
and Families
330 C Street, SW
Switzer Building, Room 2026
Washington, DC 20201

Jane A. Goldman 545
University of Connecticut
Human Development and Family
Relations Program
Box U-58, 348 Mansfield Road
Storrs, CT 06269-2058
goldman@uconnvm.uconn.edu

Lisa M. Goldman 352, 356
Region III Resource Access Project
PO Box 280
Norge, VA 23127-0280

Anne Goldstein
National Child Care Information
Center
301 Maple Avenue West, Suite 602
Vienna, VA 22180
agoldstein@acf.dhhs.gov

Deanna Gornby 57, 453
David and Lucille Packard
Foundation
Center for the Future of Children
300 2nd Street, Suite 102
Los Altos, CA 94022

Richard F. Gonzales 102
The City of New York
Administration for Children's
Services-Head Start
30 Main Street, Sweeney Building,
10th Floor
Brooklyn, NY 11201

Susan Goodwyn 309, 311
945 Weyand Way
Dixon, CA 95620
sgoodwyn@toto.scustan.edu

Kimberly A. Gordon 580
Southern Illinois University at
Carbondale
Department of Curriculum and
Instruction
323C Wham Building, MC 4610
Carbondale, IL 62901
kagordon@siu.edu

Bertha Gorham
Research Triangle Institute
PO Box 12194
Research Triangle Park, NC 27709

Jenny E. Gorman
Administration on Children, Youth
and Families
Child Care Bureau
200 Independence Avenue, SW,
Room 320F
Washington, DC 20201

Margo Gottlieb 163
Illinois Resource Center
1855 South Mount Prospect Road
Des Plaines, IL 60018-1805
margogott@aol.com

Edith M. Gozali-Lee 519
Wilder Research Center
1295 Bandana Boulevard North,
Suite 210
St Paul, MN 55108-5197
emg@wilder.org

Judy Grados
Johns Hopkins University
624 North Broadway
812 Hampton House
Baltimore, MD 21205

Sheryl B. Graves 472
Hunter College - CUNY
Department of Educational
Foundation, West 1016
695 Park Avenue
New York, NY 10021

Beth Green
University of Pittsburgh
Policy and Evaluation Project
121 University Place, Room 201
Pittsburgh, PA 15217
bigreen@vms.cis.pitt.edu

Katherine H. Greenberg 639, 678
University of Tennessee at Knoxville
Director, COGNET Education
Model
434 Claxton Addition
Knoxville, TN 37996-3400
khgreen@utk.edu

Sarah M. Greene 43, 89
National Head Start Association
1651 Prince Street
Alexandria, VA 22314
sgreene@alex.nhsa.org

Daryl B. Greenfield 127, 130, 583,
607
University of Miami
Department of Psychology
PO Box 249229
Psych Annex
Coral Gables, FL 33124-0721
dgreen@peds.med.miami.edu

Barbara Greenstein 116
407 East 91st Street
New York, NY 10128

Jonathan J. Greenstein
St. Joseph's Children's Hospital
Child Development Center
4144 North Armenia Avenue,
Suite 375
Tampa, FL 33607

Charles Greenwood 311
University of Kansas
Juniper Gardens Children's Project
1614 Washington Boulevard
Kansas City, KS 66102

Leslie K. Grier 618
Grand Valley State University
Department of Psychology, 284
AuSable Hall
Allendale, MI 49401
grier1@gvsu.edu

James Griffin 106, 186, 206
Administration on Children, Youth
and Families
Research, Demonstration, and
Evaluation Branch
330 C Street, SW
Switzer Building, Room 2411
Washington, DC 20201
jagriffin@acf.dhhs.gov

Terri M. Griffin 597
Columbia University Teachers
College
Center for Young Children and
Families
525 West 120th Street, Box 39
New York, NY 10027
tg34@columbia.edu

Desiree Griffin-Moore
Freddie Mac Foundation
8200 Jones Branch Drive
MS#259
McLean, VA 22102

Judy Grossman
277 North Avenue
Westport, CT 06880

Lindsey K. Grossman 326
Children's Hospital
Ohio State University
700 Children's Drive
Columbus, OH 43205-2696
lgrossma@magnus.acs.
ohio_state.edu

Edith H. Grotberg
4141 North Henderson Road,
Suite 1216
Arlington, VA 22203
lburchin@gmu.edu

Lawrence Grylack 640
Columbia Hospital for Women
2425 L Street, NW
Washington, DC 20037

Gilbert R. Guerin 527
San Jose State University
Division of Special Education and
Rehab Services
San Jose, CA 95192-0078

Yvonne Guerra
AVANCE San Antonio, Inc.
2300 West Commerce, Suite 304
San Antonio, TX 78207

Dominic F. Gullo
University of Wisconsin at
Milwaukee
Department of Curriculum and
Instruction
School of Education
Enderis Hall 310, PO Box 413
Milwaukee, WI 53201

Megan R. Gunnar 563, 620
University of Minnesota
Institute for Child Development
51 East River Road
176 Child Development
Minneapolis, MN 55455-0345
gunnar@vx.cis.umn.edu

Oswal Gunvant Devichand
Centre for Developmental Disorders
Sanjivani Clinic
1215 Bhavani
Peth, Pune, India 411 042

Marjorie A. Gutman 453
The Robert Wood Johnson
Foundation
Route 1 and College Road East
Princeton, NJ 08543-2316

Nan Gutshall 355
Utah State University
Early Intervention Research Institute
Center for Persons with Disabilities
Logan, UT 84322

Cynthia A. Guy 423
Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202

Patricia A. Haensly
1015 Walton Drive
College Station, TX 77840-2310
haensly@acs.tamu.edu

John W. Hagen 1, 27, 293, 360
Society for Research in Child
Development
University of Michigan
SRCD-1070 NE, 300 North Ingalls
Building
Ann Arbor, MI 48109-0406
jwhagen@umich.edu

Ann H. Hains 352, 353
University of Wisconsin-Milwaukee
Department of Exceptional
Education
1575 East Blackthorne Place
Whitefish Bay, WI 53211
annhains@csd.uwm.edu

Julie Hall 511
University of Tennessee
119 Cheesekogili Way
Loudon, TN 37774
jahall1993@aol.com

Lynne Hall 541
Early Childhood Connections
Cambridge School Department
159 Thorndike Street
Cambridge, MA 02141

Freddie Hamilton 250
Child Development Support
Corporation
119 Bedford Avenue
Brooklyn, NY 11216

Patricia Hamilton 197, 526
1800 Old Meadow Road, #112
McLean, VA 22102
STRA-IBC@cais.com

Muriel Hamilton-Lee 144, 548
Yale University
Bush Center in Child Development
310 Prospect Street
New Haven, CT 06511

Virginia R. Hampton 610, 616
University of Pennsylvania
Graduate School of Education/PED
3700 Walnut Street
Philadelphia, PA 19104-6216
ghampton@dolphin.upenn.edu

Barbara Hanley 610
The Ohio State University at Lima
The Nisonger Center UAP
4240 Campus Drive, PS#145
Lima, OH 45804

Bridget O. Hannahan 509
University of Alabama at
Birmingham
Civitan International
Research Center
SC 313, Department of Psychology
c/o Shirley L. Robinson
Birmingham, AL 35294-0017

Sydney L. Hans
5706 South Woodlawn Avenue
Chicago, IL 60637-1603

Tom L. Hansen 564
University of Nebraska-Kearney
Kearney, NE 68847

Marci J. Hanson 359
San Francisco State University
Department of Special Education
4 Tapia Drive
San Francisco, CA 94132
mjhanson@sfsu.edu

Cynthia S. Harbeck-Weber
Ohio State University
Children's Hospital
Psychology Department
700 Children's Drive
CHPB 4
Columbus, OH 43205-2666

Lawrence V. Harper 505
University of California, Davis
Department of Human and
Community Development
Hart Hall
Davis, CA 95616
lharper@ucdavis.edu

Mary S. Harper
Emprise Designs, Inc.
2121 Eisenhower Avenue, Suite 501
Alexandria, VA 22314

James A. Harrell
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Robin Harris
Children's Defense Fund -
Columbus
52 East Lynn Street, #400
Columbus, OH 43215-3508

Jordan Hart 620
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345
hart0040@gold.tc.umn.edu

Latifah Hasan 250
Dimock Community Health Center
55 Dimock Street
Roxbury, MA 02119

Barbara J. Hatcher
807 Taylor Street, NE
Washington, DC 20017-2009

T. Diane Hatcher 506
University of Connecticut
Health Center
Division of Child and Family Studies
309 Farmington Avenue, MC 6222
Farm Hollow, Suite A-200
Farmington, CT 06032

Elvira G. Hausken 133
National Center for Education
Statistics
555 New Jersey Avenue, NW
Room 417
Washington, DC 20208-0001
Elvira_Hausken@ed.gov

Mary Haust 588
MacArthur School
Community Resources
1123 Vestal Avenue
Binghamton, NY 13903

Theresa L. Hawley
The Ounce of Prevention Fund
122 South Michigan Avenue,
Suite 2050
Chicago, IL 60637

Peggy Stephens Hayden 352,
357
University of Kentucky
Mid-South Regional
Resource Center
216 Mineral Industries Building
Lexington, KY 40506-0051
hayde@nihi.ihdi.uky.edu

Janice S. Hayes 488
Miami Children's Hospital
3100 SW 62nd Avenue
Miami, FL 33155-3009
j.hayes1@mch.com

Katherine Hayes 526
Juarez and Associates
12139 National Boulevard
Los Angeles, CA 90064
juarez@ixi.netcom.com

H Carl Haywood 534
Touro College
Graduate School of Education
350 5th Avenue, Suite 5122
New York, NY 10118
haywohc@ctrvx.vanderbilt.edu

Harriet Heath
223 Buck Lane
Haverford, PA 19041-1106

Kathleen Hebbeler 290
SRI International
Health and Social Policy Division
333 Ravenswood Avenue
Menlo Park, CA 94025

Susan M. Hegland
Iowa State University
Department of Human Development
and Family Studies
101 Child Development Building
Ames, IA 50011-1030

Nancy Heiser
Mathematica Policy Research
600 Maryland Avenue, SW, Suite 55
Washington, DC 20024
nheiser@mathematica-mpr.com

James H. Heller
Duke University Medical Center
Child Development Unit
2213 Elba Street
Chapel Hill, NC 27514
Helle001@mc.duke.edu

Linda Hellerich-Tuttle 551, 673
Lincoln Action Program Family
Focus Center
Arts and Sciences
1145 High Street
Lincoln, NE 68502
lhellerich@aol.com

Laurie Hellstrom 498
Concordia University
Department of Education
1455 de Maisonneuve Ouest
Montreal, Quebec,
Canada H3G 1M8

Carolynn E. Henderson
Burlington County Community
Action Program
718 Route 130 South
Burlington, NJ 08016

Noreen Herbert 604
Maryland Department of Health and
Mental Hygiene
Mental Hygiene Administration
201 West Preston Street
Baltimore, MD 21201

Allen Herman 102, 105
National Institutes of Health
6100 Executive Boulevard,
Room 7B03
Bethesda, MD 20892
hermana@hd01.nichd.nih.gov

Ron D. Herndon 43, 89
National Head Start Association
1651 Prince Street
Alexandria, VA 22314

JoAn Knight Herren
Administration on Children, Youth
and Families
Head Start Bureau
Training and Technical Assistance
Branch
330 C Street, SW, Switzer Building,
Room 2310
Washington, DC 20201

Linda L. Hestenes 507
University of North Carolina-
Greensboro
Department of Human Development
and Family Studies
228 Stone Building
Greensboro, NC 27412-5001
lhesten@erickson.uncg.edu

Diana B. Hiatt 632
Pepperdine University
GSEP
400 Corporate Pointe, 4th Floor
Culver City, CA 90230

John S. Hicks 512
Fordham University
Graduate School of Education
13 West 60th Street
New York, NY 10023-7901

Glinda F. Hill
Vanderbilt University Medical Center
1612 Stokes Lane
Nashville, TN 37215-1512

Julie A. Hirschler 644
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02158-1060
julieh@edc.org

Margaret Hiscott 593
SUNY at Stony Brook
Department of Psychology
Stony Brook, NY 11794-2500
russgrd3@psych1.psy.sunysb.edu

Katherine G. Hoffman 646
Macro International
11785 Beltsville Drive
Calverton, MD 20705
hoffman@macroint.com

Gary Holden
RR Box 409A
Red Hook, NY 12571

Cheryl C. Holland 655
University of Maryland
Department of Psychology
Zoology/Psychology Building
College Park, MD 20742
cc122@umail.umd.edu

Holly A. Hollomon 572
University of Miami
Department of Psychology, Annex
PO Box 249229
Coral Gables, FL 33124-0721
hhollomo@child.psy.miami.edu

Susan D. Holloway
Harvard University
Department of Human Development
and Psychology
School of Education
712 Larsen Hall
Cambridge, MA 02138

Sandra J. Holmes 344, 345
Center for Pediatric Research
Children's Hospital of King's
Daughters
855 West Brambleton Avenue
Norfolk, VA 23510
sjh@cpr.ndb4.evms.edu

June Holstrom 578
Centers for Disease Control
NCEH/BDDD
4770 Buford Highway, NE, MS F-15
Atlanta, GA 30341-3724
WJHO@cehbddd.em.cdc.gov

Alice S. Honig 275, 276
Syracuse University-College for
Human Development
Department of Child and Family
Studies
201 Slocum Hall
Syracuse, NY 13244-1250
ahonig@mailbox.syr.edu

Hyman Hops
Oregon Research Institute
1715 Franklin Boulevard
Eugene, OR 97403-1983

Lyn Horine
Oregon Department of Education
255 Capitol Street, NE
Salem, OR 97310
horinel@teleport.com

Diane M. Horm-Wingerd 643
University of Rhode Island
Department of Human Development
and Family Studies
Transition Center
2 Lower College Road
Kingston, RI 02881
dianehw@uriacc.uri.edu

Eva Horn 359
Vanderbilt University
Department of Special Education
Box 328, Peabody College
Nashville, TN 37203
home@uansv5.vanderbilt.edu

Karen D. Horobin
California State University
School of Education
6000 J Street
Sacramento, CA 95819-6079
kdhorobin@csu.edu

Patricia D. Horsch
Erikson Institute
420 North Wabash Avenue
Chicago, IL 060611

Carol M. Hosaka 536
2754 Huilei Street, Apartment 1004
Honolulu, HI 96826

Alison Houck
2804 F Damascus Court
Baltimore, MD 21209
houck_ae@jhvmhs.hcf.jhu.edu

James A. Houlares 106
Community Teamwork Head Start
Child Development
Lowell Research Center
126 Phoenix Avenue
Lowell, MA 01852

Tasha R. Howe 615, 654
University of California-Riverside
Psychology Department-075
Riverside, CA 92521
wildflwr@citrus.ucr.edu

Carollee H. Howes 265, 268, 574
University of California at Los
Angeles
Department of Education
PO Box 951521
1029C Moore Hall
Los Angeles, CA 90095-1521
howes@gse.ucla.edu

Sally W. Hruska 628
Northern Michigan University
Department of Consumer and
Family Studies
1401 Presque Isle Avenue
Marquette, MI 49855-5366

Madonna Hudgens 560
Detroit Health Department
Detroit-Skillman Parenting Program
1151 Taylor, Building 4, Room 203
Detroit, MI 48202

Loreen Huffman 668
University of Mississippi
Medical Center
Department of Psychiatry and
Human Behavior
2500 North State Street
Jackson, MS 39216
lhuffman@fiona.umsmed.edu

Christine M. Hurley 656
University of Minnesota
Institute on Community Integration
150 Pillsbury Drive, SE
Minneapolis, MN 55455
hur0016@gold.tc.umn.edu

Steven Ingels 133
University of Chicago
NORC
1155 East 60th Street
Chicago, IL 60637
seingels@norcmail.uchicago.edu

Mark S. Innocenti 128, 352, 355
Utah State University
Early Intervention Research Institute
Center for Persons with Disabilities
Logan, UT 84322-6580
minno@cpd2.usu.edu

Jean M. Ispa
University of Missouri
Department of Human Development
and Family Studies
31 Stanley Hall
Columbia, MO 65211-0001
cfdjean@mizzou1.missouri.edu

Carroll E. Izard 499
University of Delaware
Department of Psychology
105 McKinly Lab
Newark, DE 19716
izard@udel.edu

Beverly R. Jackson 228, 233
Zero to Three
National Center for Infants, Toddlers
and Families
734 15th Street, NW, 10th Floor
Washington, DC 20020

Ellen V. Jacobs 498, 619
Concordia University
Department of Education
1455 Boul de Maisonneuve Ouest
Montreal, Quebec,
Canada H3G 1M8
jacobs@vax2.concordia.ca

Richard Jakopic
Administration for Children and
Families
370 L'Enfant Promenade, SW,
7th Floor West
Washington, DC 20447-0001

Susan Janko 359
University of Washington
College of Education 353600
Miller Hall
Seattle, WA 98195
sjanko@u.washington.edu

Robin Jarret 406
Loyola University of Chicago
Department of Sociology
6525 North Sheridan Road
Chicago, IL 60626
Rjarret@luc.edu

Marian H. Jarrett 568
George Washington University
Medical Center
Pride in Parenting
2134 G Street, NW
Washington, DC 20052
mjarrett@gwis2.circ.gwu.edu

Carolyn H. Jarvis 664
New York University
Robert F. Wagner Graduate School
of Public Service
4 Washington Square North
New York, NY 10025
jarvis@is.nyu.edu

Helene Jennings 646
Macro International
11785 Beltsville Drive
Calverton, MD 20705
jennings@macroint.com

Judith Jerald 175
Early Head Start Brattleboro
Vermont
Early Education Services
218 Canal Street
Brattleboro, VT 05301-3412
eedsvcj@sover.net

Shane R. Jimerson 650
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0365
jimer001@maroon.tc.umn.edu

Deborah J. Johnson
University of Wisconsin - Madison
Department of Child and Family
Studies
WCER, 1025 West Johnson Street,
Room 467
Madison, WI 53706

Doris McNeely M. Johnson 640
University of DC
912 Jessica Drive
Fort Washington, MD 20744

Dorothy R. Johnson 465, 469
EIC Head Start/NCCU
PO Drawer 549
Edenton, NC 27932-0549

Eleanor L. Johnson
US General Accounting Office
NGB-6118
GAO/441 G Street, NW
Washington, DC 20548
johnsone.hehs@gao.gov

Helen L. Johnson 577
Queens College
EECE
65-30 Kissena Boulevard
Flushing, NY 11367-0904

James E. Johnson
Penn State University
Department of Curriculum and
Instruction
College of Education
145 Chambers Building
University Park, PA 16802

Lorraine C. Johnson
North Hudson Community Action
Corporation
Head Start Program
535 41st Street
Union City, NJ 07087

Scott P. Johnson 104
University of Hartford
College of Education, Nursing and
Health Professions
200 Bloomfield Avenue West
Hiller 252
West Hartford, CT 06117-1599
scjohnso@uhavax.hartford.edu

Gloria Johnson-Powell 233
Judge Baker Children's Center
Partnership in Prevention
295 Longwood Avenue
Boston, MA 02115-5794

Tom R. Johnstone 632
Lennox School District/
Pepperdine University
GSEP
400 Corporate Pointe
Culver City, CA 90230
tj@lennox.k12.ca.us

Brenda P. Jones 226, 439, 504,
603
University of Maryland
Institute for Child Study
3304 Benjamin Building
College Park, MD 20742
bj34@umail.umd.edu

C. Wayne Jones 635
Philadelphia Child Guidance Center
4025 Chestnut Street, 3rd Floor
Philadelphia, PA 19104-3054
cwjones@mail.med.upenn.edu

Ithel Jones 679
University of Wisconsin-Milwaukee
Department of Curriculum and
Instruction
383 Enderis Hall
PO Box 413
Milwaukee, WI 53201
ijones@csd.uwm.edu

Judith E. Jones 214
Columbia University School of
Public Health
National Center for Children in
Poverty
154 Haven Avenue, 3rd Floor
New York, NY 10032-1180
jjones@aol.com

Sheila D. Jones
Department of Community
Disorders and Special Education
101 Navy Hall
Bloomsburg, PA 17815

Stephanie M. Jones 523, 605
Columbia University School of
Public Health
National Center for Children in
Poverty
154 Haven Avenue
New York, NY 10032
sj104@columbia.edu

Pameli Joshi 251
Radcliffe Public Policy Institute
10 Garden Street
Cambridge, MA 02138

Vonda Jump
Utah State University
242 East 1000 North
Logan, UT 84341
slbn@cc.usu.edu

Anne E. Just 596
California Department of Education
Research, Evaluation and
Technology Division
721 Capitol Mall
PO Box 944272
Sacramento, CA 94244-2720
ajust@cde.ca.gov

Sharon Lynn Kagan 144, 548
Yale University
Bush Center in Child Development
and Social Policy
310 Prospect Street
New Haven, CT 06511

Ruth J. Kahn 536
Family Development Resource
Center
Saint Francis Hospital and
Medical Center
54 Mountain Brook Road
West Hartford, CT 06117

Ann Kaiser 359
Family Development Resource
Box 328, Peabody
Nashville, TN 37203

Pamela J. Kaiser 348, 349
The Children's Health Council
700 Sandhill Road
Palo Alto, CA 94304

Ariel Kalil 553
University of Michigan
5201 Institute for Social Research
Ann Arbor, MI 48106
akalil@umich.edu

Melissa Kamins
Columbia University
Department of Psychology
406 Schermerhorn Hall
New York, NY 10023
melissa@psych.columbia.edu

Mireille B. Kanda 206, 326, 336
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013
mkanda@acf.dhhs.gov

Rebecca R. Kang 309
University of Washington
4545 Sandpoint Way, # 357263
Seattle, WA 98105-7263

Caren Kaplan
National Association of Social
Workers
750 1st Street, NE, Suite 700
Washington, DC 20002-4241
ckaplan@naswdc.org

Naomi Karp 242
Office of Education Research and
Improvement
US Department of Education
National Institute on EC
Development and Education
555 New Jersey Avenue, NW,
Room 522
Washington, DC 20208-5524
naomi_karp@ed.gov

Dale S. Kasab 563
Birch and Davis Associates, Inc.
The Health Policy Group
8905 Fairview Road, Suite 300
Silver Spring, MD 20910
dkasab@bdhealthpol.com

Kathy S. Katz 627
Georgetown University
Medical Center
3800 Reservoir Road, NW
Kober Cogan, 415
Washington, DC 20007
katzk@medlib.georgetown.edu

Michael J. Keane 206
The CDM Group, Inc.
5530 Wisconsin Avenue,
Suite 1660
Chevy Chase, MD 20815-4301
niaid-support@cdmgroup.com

Nancy Keefe 492
Wellesley College
Center for Research on Women
106 Central Street
Wellesley, MA 02181-8259
nkeefe@wellesley.edu

Kari Keiser 524
University of Minnesota
Department of Sociology
267 19th Avenue South
909 Social Sciences
Minneapolis, MN 55455

Lisa B. Kelly
Little Sisters of the Assumption
Family Health Service, Inc.
426 East 119th Street
New York, NY 10035

Kimberly Kendziora 603
National Institute of Mental Health
Developmental Psychology Lab
9000 Rockville Pike, Building 15K
Rockville, MD 20814
kimk@helix.nih.gov

Woodie Kessel
Maternal Child Health Bureau
HRSA
5600 Fishers Lane, HRSA/PHS
Room 18A55
Rockville, MD 20852

Sue Kessler-Sklar
410 Riverside Drive, #64
New York, NY 10025

Sherry Keys-Hebron
CAASCM
PO Box 1026
Battle Creek, MI 49016
CAASCM@aol.com

Yong Kim 355
Utah State University
Early Intervention Research Institute
Center for Persons with Disabilities
Logan, UT 84322

Karen K. King
Child Care Resource and Referral of
Central Iowa
1200 University, Suite H
Des Moines, IA 50314

Ellen E. Kisker
Mathematica Policy Research, Inc.
PO Box 2393
Princeton, NJ 08543-2393
ekisker@mathematica-mpr.com

Ed Kissam 197
Aguirre International
411 Borel Avenue, Suite 402
San Mateo, CA 94402
ekissam@aism.attmail.com

Alice L. Kitchen 403
The Children's Mercy Hospital
Social Work and Community
Services
2401 Gillham Road
Kansas City, MO 64108-4619

Harriet Kitzman 570
University of Rochester
School of Nursing
601 Elmwood Avenue, Box SON
Rochester, NY 14642
hktz@son.rochester.edu

Douglas Klafehn 1
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013-1182

Alice S. Klein
University of California, Berkeley
Institute of Human Development
1203 Tolman Hall
Berkeley, CA 94720-0001

Elisa L. Klein 614
University of Maryland
Department of Human Development
3304 Benjamin Building
College Park, MD 20742
ek17@umail.umd.edu

Jenni W. Klein
5225 Pooks Hill Road,
Apartment 929
Bethesda, MD 20814-2052

Lisa G. Klein
Ewing Marion Kauffman Foundation
4900 Oak Street
Kansas City, MO 64112-2702

Nancy K. Klein
2715 Scarborough Road
Cleveland Heights, OH 44106

Lorraine V. Klerman
University of Alabama at
Birmingham
School of Public Health
Department of Maternal and Child
Health
1825 University Boulevard,
Suite 112
Birmingham, AL 35294-2010

Nancy A. Kling 636
15601 Greenwood Circle
Piedmont, OK 73078
da7234@uokmvsu

Jane E. Knitzer 604
Columbia University School of
Public Health
National Center for Children in
Poverty
Research and Policy Analysis
154 Haven Avenue
New York, NY 10032-1180
jk340@columbia.edu

Sally A. Koblinsky 655, 661
University of Maryland-College Park
Department of Family Studies
1204 G Marie Mount Hall
College Park, MD 20742-0001
sk38@umail.umd.edu

Dafna E. Kohen 306, 307
Columbia University
Teachers College
Center for Young Children and
Families
Society for Research in
Adolescence
Box 39
New York, NY 10027-6696
dek13@columbia.edu

Claire H. Kohrman 513
La Rabida-University of Chicago
Research and Policy Center
Woodlawn Social Services Center
950 East 61st Street
Chicago, IL 60637
ckohrman@chas.uchicago.edu

Linda M. Kolbusz
School District #300
Program Development
300 Cleveland Avenue
Carpentersville, IL 60110-1977

Susan J. Kontos 265, 267, 507
Purdue University
Department of Child Development
and Family Studies
1267 Fowler House
West Lafayette, IN 47907-1269
kontos@cfs.purdue.edu

Jonathan B. Kotch 345
University of North Carolina
Maternal and Child Health
Department
Campus Box #7400
Rosenau Hall
Chapel Hill, NC 27599-7400

Esther Kresh 57, 116
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013
ekresh@acf.dhhs.gov

Lisa L. Krzysik 648
Birmingham Early Learning Center
Birmingham, AL 35203

Marcia Kurland 535
814 Ingleside
Evanston, IL 60201

Sheryl A. Kurland
Harvard University
97 Trowbridge Street
Cambridge, MA 02138
kurlansh@hugse1.harvard.edu

Gerard M. Kysela 281
The University of Alberta
C.R.A.M.E.
3-102 Education North
Edmonton, Alberta,
Canada T6G 2G5
gerry.kysela@ualberta.ca

Silvia J. La Villa 637
Kidco Child Care Center, Inc.
3630 NE 1st Court
Miami, FL 33137

Elizabeth E. LaVergne-Pinkett 665
University of Southwestern
Louisiana
Curriculum and Instruction
PO Box 42051
Lafayette, LA 70504-2051
eel2026@usi.edu

Deborah R. Labovitz
822 Pardee Lane
Wyncote, PA 19095
Labovitz@is2.nyu.edu

J. Ronald Lalley
Far West Laboratory
Center for Child and Family Studies
180 Harbor Drive
Suite 112
Sausalito, CA 94965-2844

Wendy K.K. Lam
628 Bay Ridge Avenue
Annapolis, MD 21403
lam@kkinet.kki.jhu.edu

Michael E. Lamb
NICHD-NIH
CH SS2D LCE
9190 Rockville Pike
Room 331
Bethesda, MD 20814

Richard G. Lambert 106, 544
233 Regal Drive
Lawrenceville, GA 30245

Miriam Landsman 657
The University of Iowa
School of Social Work
National Resource Center for Family
Centered Practice
112 North Hall
Iowa City, IA 52242-1223
miriam_landsman@uiowa.edu

Beverly Langford-Thomas 233
DC Public Schools
Head Start Program
S.E. Career Development Center
12th Place and Jasper Road, SE
Washington, DC 20020

Luis M. Laosa 526
Educational Testing Service
Division of Education Policy
Research
Research Building, 08-R
Princeton, NJ 08541-0001

Mary B. Larner 250
David and Lucile Packard
Foundation
Center for the Future of Children
300 2nd Street, #102
Los Altos, CA 94022
m.larner@futureofchildren.org

Lisa Breeze Lau 129
Frank P. Graham Child
Development Center
105 Smith Level Road
Chapel Hill, NC 27599-0001

Susan Law
United Child Development
1200 Arlington Street
Greensboro, NC 27406

Diana Lawrence 560
Detroit Health Department
Paraprofessional Outreach Program
1151 Taylor, Suite 606B
Detroit, MI 48202

Betty Lawton 565
Southern Illinois University at
Edwardsville
Department of Health, Recreation
and Physical Education
Edwardsville, IL 62026

Joseph T. Lawton
University of Wisconsin
Department of Child and Family
Studies
1430 Linden Drive
Madison, WI 53706-1524
jlawton@mac.wisc.edu

Jean I. Layzer 306, 308
Abt Associates
55 Wheeler Street
Cambridge, MA 02138-1125
jean_layzer@abtassoc.com

Irving Lazar
Vanderbilt University
Kennedy Center for Research in
Human Development
GPC Box 66
Nashville, TN 37212-2808

Ellen Lazzaro
National Association of WIC
Directors
1627 Connecticut Avenue, NW,
Suite 5
Washington, DC 20009

Cobbie P. Le Blanc 584
ATI Center for Child Development
5099 East Grant Road, Suite 331
Tucson, AZ 85712-2764

Larry LeFlore 549
University of Southern Mississippi
Southern Station, Box 5002
Hattiesburg, MS 39406-5002

Bonnie J. Leadbeater
Yale University
Department of Psychology
PO Box 208205
Yale Station
New Haven, CT 06520-8205

Philip J. Leaf
Johns Hopkins University
School of Public Health
624 North Broadway
Hampton House, Room 827
Baltimore, MD 21205-1901
pleaf@phnet.sph.jhu.edu

Robert K. Leik 131
University of Minnesota
Department of Sociology
267 19th Avenue South
909 Social Sciences Building
Minneapolis, MN 55455
rleik@maroon.tc.umn.edu

Emily Leish 513
Columbia University
411 West 118th Street
H303C East Campus
New York, NY 10027
eleish@lawmail.law.columbia.edu

Linda Lemesurier 498
Concordia University
Department of Education
1455 de Maisonneuve Ouest
Montreal, Quebec,
Canada H3G 1M8

Carolyn P. Leonard
Montgomery County Public Schools
Head Start
4910 Macon Road
Rockville, MD 20852

Martha Lequerica
3001 Henry Hudson Parkway
Bronx, NY 10463

Richard M. Lerner 419
Michigan State University
Institute for Children, Youth and
Families
27 Kellogg Center
East Lansing, MI 48824-1022
rlerner@msu.edu

Sharon A. Lesar 511
The University of Tennessee-
Knoxville
College of Education
Inclusive Early Childhood Unit
327 Claxton Addition
Knoxville, TN 37996-3400
shl@utkux.utk.edu

Bethany L. Letiecq 661
University of Maryland
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742
bl38@umail.umd.edu

Tama Leventhal 575
Columbia University
Teachers College
Center for Young Children and
Families
525 West 120th Street, Box 39
New York, NY 10027
tl91@columbia.edu

Marjorie Levin 186
Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138
marjorie_lein@abtassoc.com

Martynn Levin 530
The Merrill-Palmer Institute
Wayne State University
5959 Woodward
Detroit, MI 48202

Patricia W. Levin
Pennsylvania Head Start
Association
Community Services for
Children, Inc.
431 East Locust Street
Bethlehem, PA 18018-2918
pwlevin@aol.com

Eleanor Levine 572
University of Miami
Department of Psychology, Annex
PO Box 249229
Coral Gables, FL 33124-0721

Ranny Levy 472
Coalition-Quality Children's Media
535 Cordova, Suite #456
Santa Fe, NM 87501
kidsfirst@santafe.edu

H. Doneli Lewis
NCCU
Department of
Communication Disorders
PO Box 19776
Durham, NC 27707

Fen Fen Li 584
University of Arizona
Assessment Technology, Inc.
5099 East Grant Road, Suite 331
Tucson, AZ 85712

Shouming Li 359
University of Maryland
Department of Special Education
Early Childhood Research
on Inclusion
College Park, MD 20742
smli@wam.umd.edu

Carol S. Lidz 537
Touro College
Graduate School of Education and
Psychology
350 Fifth Avenue
Empire State Building, Suite 1700
New York, NY 10118
zdlisc@aol.com

Joan Lieber 359
University of Maryland
Department of Special Education
Early Childhood Research Institute
on Inclusion
College Park, MD 20742
jl39@umail.umd.edu

Cynthia Pierce Liefeld 485, 548
University of Pittsburgh
Psychology in Education
5C Forbes Quadrangle
Pittsburgh, PA 15260
cliefeld@vms.cis.pitt.edu

Carmen Lieurance
Taos Pueblo Head Start Program
PO Box 55
Taos, NM 87571-1846

Amy Liew 359
The Institute for Human and Social
Development, Inc.
San Mateo County
Head Start Program
753 Del Monte Avenue, # 9
South San Francisco, CA 94080-
2231

Priscilla Lincoln 487
Visiting Nurse Service
Maternal Child Health
5 Penn Plaza, 18th Floor
New York, NY 10001

Oliver Lindsay 560
Detroit Health Department
Healthy Baby Services
1151 Taylor, Room 426C
Detroit, MI 48202

Ann Linehan 57
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Lewis P. Lipsitt
Brown University
Department of Psychology
Hunter Lab
Box 1853
Providence, RI 02912-0001

John E. Lochman 216
Duke University Medical Center
Box 2917
Durham, NC 27710

Deborah A. Loesch-Griffin 163
Turning Point, Inc.
PO Box 8876
University Station
Reno, NV 89507-8876

Valdi Lofthouse
Bear River Head Start
75 South 400 West
Logan, UT 84321

Thomas F. Logan
East Coast Migrant Head Start
Project
PO Box 7289
Winter Haven, FL 33883-7289

Lura G. Lohr 542
50021 Brogden
Chapel Hill, NC 27514

Michelle Loiseau 599
Pacific Lutheran University
Marriage and Family Therapy
Program
East Campus
Tacoma, WA 98447

Joan Lombardi 253
Administration on Children, Youth
and Families
Child Care Bureau
200 Independence Avenue, SW
Washington, DC 20201

Sharon K. Long 498
The Urban Institute
2100 M Street, NW
Washington, DC 20037
slong@ui.urban.org

Paul Longo 526
Juarez and Associates
12139 National Boulevard
Los Angeles, CA 90064

Marcela Lopez 290
SRI, International
Health and Social Policy Division
333 Ravenswood Avenue
Menlo Park, CA 94025

Michael Lopez 106, 175, 197
Administration on Children, Youth
and Families
Research, Demonstration and
Evaluation
330 C Street, SW
Switzer Building, Room 2411
Washington, DC 20201
mllopez@acf.dhhs.gov

Raymond P. Lorion 655
University of Maryland
Department of Psychology
Zoology/Psychology Building
College Park, MD 20742
lorion@bss3.umd.edu

David W. Lounsbury 559
Michigan State University
Department of Psychiatry
Outcome Evaluation, Health Care
Study Project
B419 West Fee Hall
East Lansing, MI 48824
lounsbu@pilot.msu.edu

Fannye E. Love 465
University of Mississippi
School of Education
Department of Curriculum and
Instruction
University, MS 38677

John M. Love 116, 133, 214
Mathematica Policy Research, Inc.
PO Box 2393
101 Morgan Lane
Princeton, NJ 08543-2393
jlove@mathematica-mpr.com

John D. Lovelace
Southern Illinois University at
Edwardsville
St. Clair Head Start
411 East Broadway
East Saint Louis, IL 62201-3027

Valeria Lovelace 22, 472
Media Transformation
282 Dewey Place
Teaneck, NJ 07666

Curt Lox 565
Northern Illinois University
Department of Physical Education
DeKalb, IL 60115-2854
p20cll1@com.cso.niu.edu

Karen K. Lozano 509
University of Alabama at
Birmingham
Civitan International Research
Center
SC 313, Department of Psychology
c/o Shirley L. Robinson
Birmingham, AL 35294-0017

Betsy Lozoff 313
University of Michigan
Center for Human Growth and
Development
300 North Ingalls Street
Ann Arbor, MI 48109-0406
blozoff@umich.edu

Sara H. Lubar 352, 353
Community Intervention Program
1831 West Daisy Lane
Glendale, WI 53209

Tom Luster 623
Michigan State University
Department of Family and Child
Ecology
101 Morrill Hall
East Lansing, MI 48824-1030

Paula Luszcz 562
Christopher House
4701 North Winthrop Avenue
Chicago, IL 60640-5033

Cheryl Lutz
Community Development Institute
445 Union Boulevard, Suite 230
Lakewood, CO 80228
cdidenvr@rmi.net

Debra S. Lutz 465, 470
149 North Main Street
Cramerton, NC 28032

Kathleen Bodisch Lynch 370,
372
Virginia Commonwealth University
Virginia Institute for Developmental
Disabilities
PO Box 843020
Richmond, VA 23284-3020
klynch@felix.vcu.edu

Sandra K. Machida 585
California State University
Psychology Department
Chico, CA 95929-0234
smachida@oavax.csuchico.edu

Sandra Machleit 678
325 Gregg Road
Powell, TN 37849
machleit@utkux.utk.edu

David L. MacPhee
Colorado State University
Department of Human Development
and Family Studies
Gifford 106
Fort Collins, CO 80523-0001
macphee@condor.cahs.
colostate.edu

Sharone L. Maital 488
University of Haifa,
School of Education
Department of Education
Haifa, Israel
maitals@construct.haifa.ac.il

Judith Maloy 560
Detroit Health Department
Central Diagnostic and Referral
Service
1151 Taylor, Building 1
Detroit, MI 48205

Tammy Mann 439
Zero to Three
National Center for Infants, Toddlers
and Families
Infants Program
734 15th Street, NW, 10th Floor
Suite 1000
Washington, DC 20005

Marcia A. Manter 645
Community Development Institute
6608 Raytown Road, Suite 106
Raytown, MO 64133
cditasc7@aol.com

Panayota Youli Mantzicopoulos
675, 677
Purdue University
Department of Educational Studies
1446 Liberal Arts and
Education Building
Room 5126
West Lafayette, IN 47907-1446
mantzi@vm.cc.purdue.edu

Patricia H. Manz 147, 598, 610
9 Rivera Avenue
Titusville, NJ 08560-1709

Rebecca A. Marcon 621
University of North Florida
Department of Psychology
4567 Saint Johns Bluff Road South
Suite 5
Jacksonville, FL 32224-2645
rmarcon@unf1vm.cis.unf.edu

Sue Marcus 406
Thomas Jefferson University
Department of Biostatistics
125 South 9th Street
Sheridan, Room 403
Philadelphia, PA 19107
smarcus@lac.jci.tju.edu

Patricia P. Marickovich 102
New River Community Action, Inc.
Head Start Program
PO Box 570
106-B South Franklin Street
Christiansburg, VA 24073

Glenna Markey 116
Bear River Head Start, Inc.
75 South 400 West, PO Box 281
Logan, UT 84321

Ken Marquard 607
University of Miami
Department of Psychology
PO Box 249229
Coral Gables, FL 33124

Jules M. Marquart 359
Vanderbilt University
Department of Special Education
Box 328, Peabody College
Nashville, TN 37203
marquart@uansv5.vanderbilt.edu

Halina M. Marshall 653
University of Rochester
Primary Mental Health Project, Inc.
575 Mount Hope Avenue
Rochester, NY 14620
marshall@psych.rochester.edu

Nancy L. Marshall
Wellesley College
Center for Research on Women
106 Central Street
Wellesley, MA 02181

John Martin
Wood County Head Start
2541 7th Street South
Wisconsin Rapids, WI 54494

Julia Martino 516
4657 Park Boulevard
Oakland, CA 94062

Fern Marx 548
Wellesley College
Center for Research on Women
Wellesley, MA 02181
fmarx@lucy.wellesley.edu

Linda A. Maslowski 645
Community Development Institute
6608 Raytown Road, Suite 106
Raytown, MO 64133
cdifasc7@aol.com

Emanuel J. Mason
University of Kentucky
Department of Education and
Counseling Psychology
246 Dickey Hall
Lexington, KY 40506-0017

Jana M. Mason 586
University of Illinois
Center for the Study of Reading
51 Gerty Drive
174 Children's Research Center
Champaign, IL 61820

April Massey 520
University of the District of Columbia
Department of Communication
Sciences, MB1004
4200 Connecticut Avenue, NW
Washington, DC 20008

Ann S. Masten
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0365

Christine Burton Maxwell 352,
354
University of Wisconsin-School of
Education
Department of Curriculum and
Instruction
PO Box 413
Enderis Hall
Milwaukee, WI 53201-0413
cburton@soe.uwm.edu

Rosemary D. Mazzatenta
School District of Philadelphia
Pre-Kindergarten Head Start
Program
Stevens Administrative Center
13th and Spring Garden Streets,
Room 303
Philadelphia, PA 19123

Carol McAllister
University of Pittsburgh/EHS
Graduate School of Public Health
230 Parran Hall
Pittsburgh, PA 15261
allister@unix.cis.pitt.edu

Jeanne McBride 326, 564
ABCD Head Start
178 Tremont Street
Head Start, 9th Floor
Boston, MA 02111

Susan L. McBride 289, 291
Iowa State University
Human Development and Family
Studies
101 Child Development Building
Ames, IA 50011
mcbride1@ux1.cso.uiuc.edu

Lisa A. McCabe 641
Cornell University
Department of Human Development
and Family Studies
Martha Van Rensselaer Hall
Ithaca, NY 14850
lam4@cornell.edu

Robert B. McCall 116
University of Pittsburgh
Office of Child Development
UCSUR, 121 University Place
Pittsburgh, PA 15260
mccall2@ums.cis.pitt.edu

Cecilia M. McCarton 575
Albert Einstein College of Medicine
Rose F. Kennedy Center
1410 Pelham Parkway South
Bronx, NY 10461-1101

Karen McCluskey 505
University of California-Davis
Department of Human and
Community Development
Davis, CA 95616
ksmccluskey@ucdavis.edu

Scott R. McConnell 214, 309, 311
University of Minnesota
Institute of Community Integrations
150 Pillsbury Drive, SE
102 Pattee Hall
Minneapolis, MN 55455
smcconne@maroon.tc.umn.edu

Christine E. McCormick 586
Eastern Illinois University
Psychology Department
Charlestown, IL 61920
cfcemi@eiu.edu

Deborah McCormick
U.S. General Accounting Office
GAO/HEHS
NGB/Education and Employment
441 G Street, NW
Washington, DC 20548
mccormickd.hehs@gao.gov

Marie McCormick 575
Harvard School of Public Health
Department of Maternal and Child
Health
677 Huntington Avenue
Boston, MA 02115

J. Kelly McCoy 595
Brigham Young University
Department of Family Science
1000 SWKT
PO Box 25317
Provo, UT 84602-5317
jkmccoy@byu.edu

Duncan McCulloch 604
Center for Infant Study
408 West Lombard Street
Baltimore, MD 21201

Judith McCullough 633
University of Denver
Department of Psychology
2155 South Race Street
Frontier Hall
Denver, CO 80208
jmccullo@pstar.psy.du.edu

Linda McDonald 281
University of Alberta
Department of Educational
Psychology
6-102 Education North
Edmonton, Alberta,
Canada T6G 2G5
linda.mcdonald@ualberta.ca

Liz McDougall 281
Coalition of Rural Representatives
Breton/Buck Creek
Box 779
Breton, Alberta, Canada T0C 0P0

Teresa McDowell 599
Pacific Lutheran University
Marriage and Family Therapy
Program
East Campus
Tacoma, WA 98447

Sandra McElhaney 214, 311
National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
nmhaprev@aol.com

Mary A. McEvoy 214, 311
University of Minnesota
Center for Early Education and
Development
150 Pillsbury Drive, SE
215 Pattee Hall
Minneapolis, MN 55455
mary@vx.cis.umn.edu

Anne McGill-Franzen
SUNY at Albany
School of Education
Department of Reading
1400 Washington Avenue
ED 333
Albany, NY 12222-0001

Joseph B. McGlinchey 666, 667
Columbia University
1230 Amsterdam Avenue
Whittier Hall, 724
New York, NY 10027
jbm1b@columbia.edu

Brenda G. McGowan 423, 425
225 East 79th Street, 13B
New York, NY 10021
bgm1@columbia.edu

Sharon M. McGroder 622
6771 Old Waterloo Road, #537
Elkridge, MD 21227
smm153@psuvm.psu.edu

Carol A. McHenry
Lycoming-Clinton Head Start
2138 Lincoln Street
Williamsport, PA 17701

Ruth Hubbell McKey
Elisworth Associates, Inc.
8381 Old Courthouse Road
Suite 200
Vienna, VA 22182-3818

Sue McLaren
Chatterbox Playgroup
22 Troubridge Retreat
Ocean Reef, W.A., Australia 6027

Joan E. McLaughlin 175
Abt Associates, Inc.
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814
joan_mclaughlin@abtassoc.com

Jeffrey A. McLellan 550
CSR, Inc.
1400 Eye Street, NW, Suite 200
Washington, DC 20005-2208
jamclellan@radix.net

Marsha McMurray 345
University of North Carolina
Frank Porter Graham Child
Development Center
Campus Box 8180
Chapel Hill, NC 27599

Joan Meier
George Washington University Law
School
Taylor Institute
720 20th Street, NW
Washington, DC 20052

John H. Meier 515
Preschool Services Department
Disabilities Services Division
250 South Lena Road
San Bernardino, CA 92408

Samuel J. Meisels 133
University of Michigan
School of Education
610 East University
1225 SEB
Ann Arbor, MI 48109-1259
smeisels@umich.edu

Gary B. Melton
Institute for Families In Society
University of South Carolina
Columbia, SC 29208

Julia L. Mendez 616
University of Pennsylvania
Graduate School of Education/PED
3700 Walnut Street
Philadelphia, PA 19104-6216
jmendez@dolphin.upenn.edu

Barbara Merrill
Governor's Cabinet On Children and
Families
Building 1, Room 9,
Capitol Complex
Charleston, WV 25305

Norweeta G. Milburn
28 Beechwood Road
Hartsdale, NY 10530-1620

Beth M. Miller 250, 251, 676
Wellesley College
Center for Research on Women
School-Age Childcare Project
106 Central Street
Wellesley, MA 02181-8259
bmiller@wellesley.edu

Laurie Miller 216
NYSPi-Columbia University
Department of Child Psychiatry
722 West 168th Street, Unit 60
New York, NY 10032-2603
millerl@child.cpmc.columbia.edu

Pamela B. Miller 543, 611
Harvard University Graduate School
of Education
Harvard Family Research Project
38 Concord Avenue
Cambridge, MA 02138
miller@hugsel.harvard.edu

Regina M. Miller 102, 104
University of Hartford
College of Education, Nursing and
Health Professions
200 Bloomfield Avenue
Hillyer Room 252
West Hartford, CT 06117-1599
remiller@uhavax.hartford.edu

Shelby H. Miller
412 East 55th Street, Apartment 3G
New York, NY 10022

Kay Mills
1129 Ashland Avenue
Santa Monica, CA 90405

Charles H. Mindel 495
University of Texas at Arlington
School of Social Work
Center for Research, Evaluation and
Technology
Box 19129
Arlington, TX 76019
mindel@uta.edu

Ann Minnis 594
Texas Instruments Foundation
PO Box 650311
MS 3906
Dallas, TX 75265-0311
afm@mimi@magic.ftg.ti.com

Jayanthi Mistry 541
Tufts University
Eliot-Pearson Department of
Child Study
105 College Avenue
Medford, MA 02155
jmistry@emerald.tufts.edu

Karen Mitchell
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Jennifer Mitchell-Copeland 502,
600
George Mason University
Psychology Department
Mailstop 3F5
Fairfax, VA 22030-4444
jmitch2@vms1.gmu.edu

Margaret Mobley
Research Triangle Institute
PO Box 12194
Research Triangle Park, NC 27709

Taghi Modarressi 604
Center for Infant Study
408 West Lombard Street
Baltimore, MD 21201

John Modell 374
Brown University
Center for the Study of Human
Development
PO Box 1938
Providence, RI 02912-1938

Holly J. Mohler 587
602 Carolina Avenue
Altoona, PA 16602

Joan Moir 547
University of Maryland
Eastern Shore
Department of Human Ecology
Princess Anne, MD 21853
jmoir@umes.bird.umd.edu

Shahnaz Mondanipour
Lycoming-Clinton Head Start
2138 Lincoln Street
PO Box 3568
Williamsport, PA 17701

Elba I. Montalvo
Committee for Hispanic Children
and Families, Inc.
140 West 22nd Street, Suite 301
New York, NY 10011-2420

Guillermo Montes 653
Primary Mental Health Project, Inc.
275 Mt. Hope Avenue
Rochester, NY 14620
montes@psych.rochester.edu

Judy K. Montgomery 508
Chapman University
Orange, CA 92666

Evelyn K. Moore 27, 360
National Black Child
Development Institute
1023 15th Street, NW
Suite 600
Washington, DC 20005-2602

Lin Moore 670
Head Start/Public School Transition
Project
Lincoln Instructional Center
5000 South Oakland Avenue
Dallas, TX 75215

Martha Moorehouse
Department of Health and Human
Services
200 Independence Avenue, SW
Washington, DC 20201-0004

Carolyn Morado
2712 Towner Boulevard
Ann Arbor, MI 48104-5058

Robert P. Moreno 518
University of Illinois
Department of Human and
Community Development
905 South Goodwin Avenue
174 Bevier Hall
Urbana, IL 61801
rmoreno@w2.cso.uiuc.edu

Gwen Morgan 265
Work/Family Directions
930 Commonwealth Avenue South
Boston, MA 02215-1212

Sheila Morgenstern
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Christine Morin 275, 276
Georgetown University
PO Box 622
College Park, MD 20740
morinc@medlib.georgetown.edu

Colleen E. Morisset 284, 309, 310
University of Washington
School of Public Health
CHDD, Box 357230
Seattle, WA 98195-9720
morisset@u.washington.edu

Pamela A. Morris 487
Cornell University
Human Development and Family
Studies
14 MVR Hall
Ithaca, NY 14853
pam6@cornell.edu

Frederick J. Morrison
Loyola University of Chicago
Department of Psychology
6525 North Sheridan Road
Chicago, IL 60626

Ardythe L. Morrow 345
Eastern Virginia Medical School
Center for Pediatric Research
855 West Brambleton Avenue
Norfolk, VA 23510-1001

Donald E. Mowrer 528, 533
5001 East Cambridge
Phoenix, AZ 85008
mowrer@imap1.asu.edu

Claudia M. Mueller 625
Columbia University
Department of Psychology
1190 Amsterdam Avenue
New York, NY 10027
claudia@psych.columbia.edu

Daniel P. Mueller 519, 671
Wildier Research Center
1295 Bandana Boulevard North,
Suite 210
Saint Paul, MN 55108-5197

Nancy Mullin-Rindler 492
Wellesley College
Center for Research on Women
Wellesley, MA 02181
nmullinrindl@wellesley.edu

Robinson Munoz-Millan 604
UMAB
Center for Infant Study
408 West Lombard Street
Baltimore, MD 21201
rmunoz@umpsy.ab.umd.edu

Carlina Seine Murphy 561
Mobile Dental Services
PO Box 35, Church Street
Niverville, NY 12130

J. Edward Murphy 561
Mobile Dental Services
PO Box 35, Church Street
Niverville, NY 12130

Linda Musun-Miller
University of Arkansas at Little Rock
Psychology Department
2801 South University Avenue
Little Rock, AR 72204-1099
lmmiller@ualr.edu

Barbie Nadal 640
Hartford Head Start
Community Renewal Team
55 Windsor Street
Hartford, CT 06120

Prasanna Nair 567
University of Maryland
Department of Pediatrics
700 West Lombard Street,
2nd Floor
Baltimore, MD 21201-1069

Jorge M. Nakamoto
Aguirre International
411 Borel Avenue, Suite 402
San Mateo, CA 94402
jnakamoto@aism.attmail.com

Olivia C. Nania 145, 500
SUNY-Stony Brook
Department of Psychology
Stony Brook, NY 11794-2500
russgrd1@psych1.psy.sunysb.edu

John H. Neel 531
Georgia State University
Department of Educational Policy
Studies
University Plaza
Atlanta, GA 30303-3083
jneel@gsu.edu

Bryan Nelson 336
PICA Head Start
2420 31st Avenue South
Minneapolis, MN 55406-1470
bgnelson@aol.com

Stacey Neuhaarh-Pritchett 675,
677
Purdue University
Department of Educational Studies
5125 LAEB
W Lafayette, IN 47907-1446
pritchsm@vm.cc.purdue.edu

Katherine Nitz 486
University of Maryland School of
Medicine
Division of Adolescent Medicine
120 Penn Street, 1st Floor
Baltimore, MD 21201
knitz@umabnet.ab.umd.edu

Ralph Da Costa Nunaz 660
Homes for the Homeless
36 Cooper Square, 6th Floor
New York, NY 10003
hn4061@handsnet.org

Ahmad Nurridin 524
700 7th Street, SW
Washington, DC 20024
anurrid@hr.hq.nasa.gov

Joanne R. Nuras 663
Georgia State University
Center for the Study of Adult
Literacy
University Plaza
Atlanta, GA 30303
litjn@gsumg2.gsu.edu

Barbara Nusbaum 577
27 West 86th Street
New York, NY 10023

Omeri Nwachi 539
TCN-Head Start
4 Meigs Street
Rochester, NY 14607

Geraldine O'Brien
East Coast Migrant Head Start
Project
4200 Wilson Boulevard
Suite 740
Arlington, VA 22203-1800

James O'Brien
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013-1182

Robert W. O'Brien 206
The CDM Group
5530 Wisconsin Avenue
Suite 1660
Chevy Chase, MD 20815
bobrien@samhsa.gov

Patricia O'Campo 640
Johns Hopkins University
Department of Maternal and Child
Health
624 North Broadway
Baltimore, MD 21205

Mary J. O'Connor
UCLA Neuropsychiatric Institute
Psychiatry
760 Westwood Plaza
48-243C NPI
Los Angeles, CA 90024

Susan O'Connor 251, 676
Wellesley College
Center for Research on Women
School-Aged Child Care Project
106 Central Street
Wellesley, MA 02181-8259

Jennifer O'Kane 638
4 Roosevelt Avenue
Patchogue, NY 11772

Ruth Ann O'Keefe
5863-B Post Corners Trail
Centerville, VA 22020

Robin O'Neill 654
University of California-Riverside
Department of Psychology-075
Riverside, CA 92521

Julia T. O'Sullivan 590
Memorial University of
Newfoundland
Faculty of Education
St John's, Newfoundland,
Canada A1B 3X8
josullivan@kean.ucs.mun.ca

Charles N. Oberg 336
Hennepin Faculty Associates
914 South 8th Street
600 HFA Building
Minneapolis, MN 55404
chuck.oberg@co.hennepin.mn.us

Frank Oberklaid
University of Melbourne
Royal Children's Hospital
Flemington Road
Parkville, Victoria, Australia 3052

Sherri L. Oden 275, 278
High/Scope Education Research
Foundation
Research Division
600 North River Street
Ypsilanti, MI 48198-2898
hsresearch@aol.com

Samuel L. Odom 359
Early Childhood Research Institute
on Inclusion
Department of Special Education
Vanderbilt University
PO Box 328, Peabody College
Nashville, TN 37203
odom@uansv5.vanderbilt.edu

Karen Ogston
130 Slater Street, Suite 810
Ottawa, Ontario, Canada K1P 6E2

Lynn R. Okagaki 507
Purdue University
Department Child Development and
Family Studies
1267 CDFS Building
W. Lafayette, IN 47907-1267
reiko@vm.cc.purdue.edu

Virginia Okoloko 106
High/Scope Education Foundation
Head Start Quality Research Center
8380 Glendale Drive
Ypsilanti, MI 48198

David L. Olds 570
University of Colorado Health
Science Center
Prevention Research Center for
Family and Child
303 East 17th Avenue, Suite 200
Denver, CO 80203
olds@disney.hsc.colorado.edu

Luis E. Ortiz
SIPAF-Rio Piedras Clinical and
Training Institute
PO Box 21257
San Juan, Puerto Rico 00928

Sheila A. Ortiz
SIPAF/Rio Piedras Clinical and
Training Institute
PO Box 21257
San Juan, Puerto Rico 00928

Jean Osborn
174 Children's Research Center
51 Gerdy Drive
Champaign, IL 61820-7407

Joy D. Osofsky
Louisiana State University School of
Medicine
Department of Psychiatry
1542 Tulane Avenue
New Orleans, LA 70112

Margaret T. Owen
University of Texas at Dallas
PO Box 830688
GR41
Richardson, TX 75083-0688

Sandra L. Owen 544
2479 Peachtree Road, NE, #1205
Atlanta, GA 30305
kinslo@langate.gsu.edu

Ura Jean Oyemade-Bailey 439
10504 Pinedale Drive
Silver Spring, MD 20901

Linda Pagani 636
GRIP-University of Montreal
School of Psycho-Education
750 Gouin Boulevard East
Montreal, Quebec,
Canada H2C 1A6
paganikl@brise.ere.umontreal.ca

Judith S. Palfrey 326
Boston Children's Hospital
Division of Ambulatory Pediatrics
300 Longwood Avenue, Gardner 8
Boston, MA 02115

Barbara Alexander Pan
Harvard Graduate School of
Education
Larsen Hall
Cambridge, MA 02138
snowbp@hugse1.harvard.edu

Tina Pantan 640
Hartford Head Start
Community Renewal Team
55 Windsor Street
Hartford, CT 06120

Ross D. Parke 615, 654
University of California-Riverside
Department of Psychology-075
Riverside, CA 92521

Faith Lamb Parker 1, 102, 144
Columbia School of Public Health
CPFH
60 Haven Avenue, B3
New York, NY 10032
flpi@columbia.edu

John M. Pascoe 313, 326, 336
University of Wisconsin
University Children's Hospital
Department of Pediatrics
600 Highland Avenue
H4/442 Clinical Science Center
Madison, WI 53792-4116
pascoe@mac.wisc.edu

Zan Payne 658, 659
Idaho State Department of
Education
Homeless Education
Box 83720
Boise, ID 83720-0027
zpayne@ide.state.id.us

Patricia Pearson 420
Suffolk Network on
Adolescent Pregnancy
PO Box 5109
Bayshore, NY 11706-0082

Norman A. Peart 546
University of North Carolina-
Chapel Hill
Frank Porter Graham Child
Development Center
105 Smith Level Road, CB 8180
Chapel Hill, NC 27599-8180
peart.fpg@mhs.unc.edu

Lenore M. Peay
Ft. George Community
Enrichment Center
1525 Saint Nicholas Avenue
New York, NY 10033-2604

Laura Peck 496
Abt Associates
55 Wheeler Street
Cambridge, MA 02138
laura_peck@abtassoc.com

Walter Pedigo
Community Development Institute
445 Union Boulevard, Suite 330
Lakewood, CO 80228
wpedigo@carbon.cudenver.edu

Ellen S. Peisner-Feinberg
University of North Carolina
Frank Porter Graham Child
Development
CB 8040, Suite 300, Nations Bank
Plaza
Chapel Hill, NC 27599-8040
peisnerf.fpgnb3@mhs.unc.edu

Irma Perez-Johnson 214
Mathematica Policy Research, Inc.
101 Morgan Lane
PO Box 2393
Princeton, NJ 08543-2393

Joan Pernica
Dimock Community Health Center
55 Dimock Street
Roxbury, MA 02119

Ruth Perou 578
Centers for Disease Control
NCEH/BDDDD
4770 Buford Highway, NE, MS F-15
Atlanta, GA 30341-3724
rperou4@cehbdd.em.cdc.gov

Carol B. Perroncel
Appalachia Educational Laboratory
Evaluation and Planning Unit
PO Box 1348
Charleston, WV 25325
perroncc@aol.org

Judy Perry
A.C.S./Head Start
30 Main Street, 10th Floor
Brooklyn, NY 11201

Ray DeVere Peters 281, 282
Queen's University
Department of Psychology
Kingston, Ontario, Canada K9L 3N6
petersrd@qucon.queensu.ca

Carla Peterson 291
Iowa State University
Human Development and Family
Studies
101 Child Development Building
Ames, IA 50011
carlapet@iastate.edu

Roy Peterson 57
Mott Children's Health Center
806 Tauri Place
Flint, MI 48503

Steven I. Pfeiffer 666, 667
131 Lisa Drive
Paoli, PA 19310

Carola Pfortner 540
CESAS
626 East Slifer Street
Portage, WI 53901
Carolapf@aol.com

Horace Phelps 668
222 East State Street
Trenton, NJ 08608

Kary Phelps
Kankakee County Head Start
710 North Chicago
Kankakee, IL 60901

Lillian A. Phenice
167 Maplewood Drive
East Lansing, MI 48823

Deborah A. Phillips 57, 149
National Academy of Sciences
Board on Children and Families
2101 Constitution Avenue, NW
Harris Building, Room 156
Washington, DC 20418-0007
phillips@nas.edu

Marian Phillips 511
225 Shadowfax Road
Knoxville, TN 37972
marianp@utkx.utcc.utk.edu

Ellen E. Pinderhughes 293
Vanderbilt University
Human Development
Peabody College, Box 512
Nashville, TN 37203
pindersee@otrvax.vanderbilt.edu

Vicki D. Pinkston
National Black Child Development
Institute
1023 15th Street, NW, Suite 600
Washington, DC 20005

Vincenza Piscitelli 517
Pace University
Department of Psychology
41 Park Avenue
Dyson College of Arts and Sciences
New York, NY 10038

Peggy Daly Pizzo
Yale University
Bush Center in Child Development
and Social Policy
5506 Uppingham Street
Chevy Chase, MD 20815-5508

Michele A. Plutro 163
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013-1182
mplutro@acf.dhhs.gov

John Poertner
University of Kansas
School of Social Welfare
Twenty Hall
Lawrence, KS 66045-0001

N. Sandy Pope
United CAP Head Start
PO Box 384
Pawnee, OK 74058

Gail Porath 354
Community Relations Social
Development Commission
Head Start
231 West Wisconsin Avenue
Milwaukee, WI 53203-2306

Leroy Potts
Temple University
Social Administration
13th Street and C.B. Moore Avenue
Ritter Hall Annex, #548
Philadelphia, PA 19122

Douglas R. Powell
Purdue University
Child Development and Family
Studies
CDFS Building
West Lafayette, IN 47907-1267

Gregg Powell 57
National Head Start Association
Research and Evaluation
1651 Prince Street
Alexandria, VA 22314
cgpowell@aol.com

Jane L. Powers
Cornell University
Family Life Development Center
G20 MVR Hall
Ithaca, NY 14853

Beverly Pringle 269
University of Maryland
Baltimore County
1000 Hilltop Circle
Baltimore, MD 21250

Adele Proctor
1065 Baytowne Drive,
Apartment #24
Champaign, IL 61821

Trult R. Prosper
Comprehensive Dental Care
2500 Wisconsin Avenue, NW,
Suite 112
Washington, DC 20007-4504

Elizabeth Quinn
CSR, Inc.
1400 Eye Street, NW, Suite 200
Washington, DC 20005
lizquinn@erols.com

Norma L. Radin 631
University of Michigan
School of Social Work
1065 Frieze Building
Ann Arbor, MI 48109-1285
nradin@umich.edu

Yvonne Rafferty 517
Pace University
Department of
Psychology/Children's Institute
Dyson College of Arts and Sciences
41 Park Row, 13th Floor
New York, NY 10038-1508
rafferty@pacevm.dac.pace.edu

Helen H. Raikes 116, 175, 551,
673
SRI Institute
The Gallup Organization
300 South 68th Street Place
Lincoln, NE 68510
raikhh@gallup.com

Craig T. Ramey 163
University of Alabama
Civitan International
Research Center
1719 6th Avenue South
Birmingham, AL 35294-0021

Sharon L. Ramey 163
University of Alabama
Civitan International
Research Center
1719 6th Avenue South
Birmingham, AL 35294-0021

Judith V. Ramirez
California State University Fullerton
Child Development
PO Box 34080
EC105
Fullerton, CA 92634-9480

Arnaldo J. Ramos
1 Washington Square Village
Apartment 4-O
New York, NY 10012

Brooke P. Randell 144
University of Washington
Department of Psychosocial and
Community Health Nursing
Seattle, WA 98195
bprand@u.washington.edu

Suzanne M. Randolph
University of Maryland
Department of Family Studies
1204 Marie Mount Hall
College Park, MD 20742-0001
srzz@umail.umd.edu

Jody Raphael 555
Taylor Institute
915 North Wolcott Street
Chicago, IL 60302

Sue P. Rasher 163
OER Associates
615 Knox Avenue
Wilmette, IL 60091-2116
oersuer@aol.com

Elaine Raspe-Borth 540
7435 Mariner Drive
Maple Grove, MN 55311
bort.0002@gold.tc.umn.edu

Virginia A. Rauh 400, 406
Columbia University School of
Public Health
CPFH
60 Haven Avenue, B-3
New York, NY 10032
var1@columbia.edu

C. Cybele Raver 654
Cornell University
Department of Human Development
and Family Studies
MVR Hall, G65
Ithaca, NY 14853
ccr4@cornell.edu

Pamela A. Raya 543
Harvard University Graduate School
of Education
Human Development and
Psychology
Appian Way
Cambridge, MA 02138

Linda H. Reasoner
Basic Health Management, Inc.
523 Louisiana Street
Suite 303
Little Rock, AR 72201-5703
BHMlinda@aol.com

Pia M. Rebellio 597
Teachers College, Columbia
University
Center for Young Children and
Families
525 West 120th Street, Box 39
New York, NY 10027
pmr11@columbia.edu

Linda A. Reddy 666, 667
Fairleigh Dickinson University
Department of Psychology
1000 River Road
Teaneck, NJ 07666

Yvonne B. Reedy
Cen-Clear Child Services, Inc.
Education
33 Irvin Drive
Philipsburg, PA 16866-3010

Thomas M. Reischl 559
Michigan State University
Department of Psychology
135 Snyder Hall, Outcome
Evaluation
East Lansing, MI 48824-1117
reischl@pilot.msu.edu

David Renz 645
University of Missouri, Kansas City
Midwest Center for Nonprofit
Leadership
5110 Cherry Street
Kansas City, MO 64110

Lauren B. Resnick
University of Pittsburgh
Learning Research and
Development Center
3939 Ohara Street
824 LRDC Building
Pittsburgh, PA 15260

Arthur J. Reynolds 275, 277
University of Wisconsin-Madison
School of Social Work
1350 University Avenue
Madison, WI 53706
ajreynol@facstaff.wisc.edu

E. Anne Rice 530
City of Detroit Human Services
Department
Child Development Division
5031 Grandy
Detroit, MI 48211

Mike L. Rice, Jr. 43, 89
Texas Instruments Foundation
PO Box 650311, MS 3906
Dallas, TX 75206

Guyllaine L. Richard
20412 Foxwood Terrace
Germantown, MD 20876

Brad Richardson 657
The University of Iowa, School of
Social Work
National Resource Center for Family
Centered Practice
112 North Hall
Iowa City, IA 52242-1223
brad_richardson@uiowa.edu

Philip A. Richardson 550
Maximus, Inc.
1365 Beverly Road
McLean, VA 22101
prichards@maximus_inc.com

Beth A. Richman 566
Children's Television Workshop
1 Lincoln Plaza, 3rd Floor
New York, NY 10023
brichman@panix.com

Julius B. Richmond 75
Harvard Medical School
Department of Social Medicine
641 Huntington Avenue
Boston, MA 02115-6019
jrichmon@warren.med.harvard.edu

Susan A. Riedinger
Mathematica Policy Research
600 Maryland Avenue, SW, #550
Washington, DC 20024
sriedinger@mathematica-mpr.com

Joseph Rigatuso 563
Healthpartners Como Clinic
2500 Como Avenue
St. Paul, MN

Kristin Riggins-Caspers 636
Iowa State University
Department of HDFS
101 Child Development
Ames, IA 50011
kcaspers@iastate.edu

Catherine Riley
All Indian Pueblo Council
3939 San Pedro, NE, Suite D
Albuquerque, NM 87190

Phoebe Rinkel 403
K.C.M.C.
2104 East 18th
Kansas City, MO 64127

Carol H. Ripple
Yale University
Bush Center in Child Development
and Social Policy
Department of Psychology
PO Box 208205
New Haven, CT 06520-8205
ripple@yalevm.cis.yale.edu

Carmen A. Rivera 284, 286
c/o PSED Head Start
400 SW 152nd Street
Burien, WA 98116-2209

Marisa Rivera
2310 Prairie View West, #105
Ames, IA 50010
marisa@iastate.edu

Lynne Robertson
Aboriginal Head Start
Health Canada
320-1975 Scorth Street
Regina, Saskatchewan, Canada
S4P 2H1

Wendy W. Robeson
Wellesley College
Center for Research on Women
828 Washington Street
Wellesley, MA 02181
wrobeson@wellesley.edu

Elaine Pierrel Robey 646
Macro International, Inc.
11785 Beltsville Drive
Calverton, MD 20705
robery@macroint.com

David S. Robinson
MSPCC
43 Mt. Vernon Street
Boston, MA 02165
drobinson@vmsvax.simmons.edu

Dina L. Robinson
NIDR/NIH
45 Center Drive, Room 3AN-44D
Bethesda, MD 20892-6401
larachd@de45.nidr.nih.gov

Joann L. Robinson
Prevention Research Center for
Family and Child Health
303 East 17th Street, Suite 200
Denver, CO 80203
JoAnn.Robinson@uchsc.edu

Michaelle Ann Robinson 556
Utah State University
Center for Persons with Disabilities
Community-Family Partnership
Comprehensive Child Development
Program
Logan, UT 84322-6825

Shirley L. Robinson 509
University of Alabama at
Birmingham
Civitan International Research
Center
SC 313, Department of Psychology
Birmingham, AL 35294-0017

Tommie L. Robinson, Jr. 520
Scottish Rite Center for
Childhood Language Disorders
1630 Columbia Road, NW
Washington, DC 20009

Carmen G. Rodriguez
Columbia University Head Start
Public Health
601 West 168th Street, #42
New York, NY 10032
CR14@columbia.edu

Lori A. Roggman 116
Utah State University
Department of Family and Human
Development
Family Life Building, Floor 214
UMC 2905
Logan, UT 84322-2905
falori@cc.usu.edu

Francine Romo
AVANCE San Antonio, Inc.
2300 West Commerce, Suite 304
San Antonio, TX 78207

Harriett D. Romo 558
Southwest Texas State University
Department of Sociology
601 University Drive
San Marcos, TX 78666-4616
h.romo@mail.utexas.edu

Joyce A. Rookwood
ACF-Head Start-Region II
26 Federal Plaza, Room 1243
New York, NY 10278-0001

Judith Rosen
Fairfax County Office for Children
Head Start
3701 Pender Drive, 5th Floor
Fairfax, VA 22030-6045

Tove Rosen 577
Columbia Presbyterian Medical
Center
Department of Pediatrics
3959 Broadway
New York, NY 10032

Leon A. Rosenberg
Johns Hopkins University
School of Medicine/Psychiatry
CMSC 396, John Hopkins Hospital
600 North Wolfe Street
Baltimore, MD 21287-3325

Shira Rosenblatt
1019 Corning Street
Los Angeles, CA 90035-2003
shira@ucla.edu

Lawrence I. Rosenkoetter 352,
356
Bethany College
Department of Psychology
300 North 1st Street
Lindsborg, KS 67456
rosenkoel@bethany.bethanylib.edu

Sharon E. Rosenkoetter 352, 356
Yale University
Associated Colleges of
Central Kansas
105 East Kansas Avenue
McPherson, KS 67460
asharonr@acck.edu

Baillie Rosenthal 106
Bussey Center for Early Childhood
Education
Southfield Public Schools
19080 West 12 Mile Road
Southfield, MI 48076-2542
br10sfd@atlas.moa.net

Ann Rosewater 14
Administration on Children and
Families
370 L'Enfant Promenade
Suite 600
Washington, DC 20447-0001

Saul R. Rosoff
6544 Sulky Lane
Annandale, VA 22003-2049

Dianne Rothenberg
ERIC Clearinghouse on Elementary
and Early
Childhood Education
University of Illinois at Urbana-
Champaign
805 West Pennsylvania Avenue
Urbana, IL 61801
rothenbe@uiuc.edu

Lenore Rubin 284, 287
Seattle-King County
Department of Public Health
2124 4th Avenue
Seattle, WA 98121

Tonja Rucker 521
3104 Taylor Street, Apartment 4
Mt Rainier, MD 20712
tr26@uemail.umd.edu

Barbara J. Rudin
Caliber Associates, Inc.
10530 Rosehaven Street, Suite 400
Fairfax, VA 22030
rudinb@calib.com

Karen Rush 311
University of Minnesota
Center for Early Education and
Development
150 Pillsbury Drive, SE
215 Pattee Hall
Minneapolis, MN 55455

Mary Lou Rush
Ohio Department of Education
65 South Front Street, Room 309
Columbus, OH 43215

Rebecca S. Russell 653
Newark School District
11 Creek Ridge
Pittsford, NY 14534

Jean Rustici 144
Yale University
Bush Center in Child Development
and Social Policy
310 Prospect Street
New Haven, CT 06511

Gina Ruther 374
Southern Illinois University at
Edwardsville
University Services to East St. Louis
Project Head Start
411 East Broadway, Building #383
East St. Louis, IL 62201

Sir Michael Rutter 27, 360
MRC Child Psychiatry Unit
Institute of Psychiatry
De Crespigny Park
Denmark Hill
London, England SE5 8AF

Paul Ryer 186
RMC Research Corporation
522 SW 5th Avenue, #1407
Portland, OR 97204
paul_ryer@rmccorp.com

Steffen L. Saifer 144, 145, 612
Portland State University
Early Childhood Training Center
PO Box 1491
Portland, OR 97207-1491
steffen@ses.pdx.edu

Rosalyn T. Saltz
18295 Parkside
Detroit, MI 48221

Faith L. Samples 228, 523, 552
Columbia University School of
Public Health
National Center for Children in
Poverty
154 Haven Avenue, 3rd Floor
New York, NY 10032
FLS13@columbia.edu

Juanita H. Santana 57, 389
Oregon Child Development Coalition
PO Box 2780
Winstonville, OR 97070
jsantanah@aol.com

Sebastiano Santostefano 501
Institute for Child Development and
Adolescent Development, Inc.
169 Grove Street
Wellesley, MA 02181-7003

Susan Santostefano 501
Institute for Child Development and
Adolescent Development, Inc.
169 Grove Street
Wellesley, MA 02181

Donna Scandlin 290
University of North Carolina
Frank Porter Graham Child
Development Center
CB 8180
Chapel Hill, NC 27599-8180

William Scarbrough
CSR, Inc.
1400 Eye Street, NW, Suite 200
Washington, DC 20005

Elaine Schaeffer 541
Cambridge Community Partnership
CEOC
11 Inman Street
Cambridge, MA 02139

Peter Schafer 640
Healthy Start, Inc.
303 East Fayette, 2nd Floor
Baltimore, MD 21202

Mark H. Schauer 43, 89
Human Services Coordinating
Council
245 West Michigan
Battle Creek, MI 49017
mark_schauer@fc1.gln.org

Linda J. Scheer
New York University
Resource Access Project-Region II
239 Greene Street
New York, NY 10003
scheerl@is3.nyu.edu

Deborah Scher 269
University of Maryland
Baltimore County
Department of Psychology
5401 Wilkens Avenue
Baltimore, MD 21228-5398

Jeanie Schiefelbusch 402, 403
Juniper Gardens Children's Project
1614 Washington Boulevard
Kansas City, KS 66102

Rachel F. Schiffman
Michigan State University
A230 Life Sciences
East Lansing, MI 48824
rschiff@msu.edu

Diane Schilder 571
Harvard Family Research Project
38 Concord Avenue
Cambridge, MA 02138-2357
schildi@hugse1.harvard.edu

Kari Schlachtenhaufen 102, 103,
551
The Skillman Foundation
600 Renaissance Center,
Suite 1700
Detroit, MI 48243

Amy Schlessman-Frost
University of Arizona
TEEM Follow Through
1415 North Fremont Avenue
COE Annex
Tucson, AZ 85719-4116

Diane Schmidt 269
University of Maryland
Baltimore County
Department of Psychology
5401 Wilkens Avenue
Baltimore, MD 21228-5398

Susan Schneider 627
Georgetown University
Medical Center
Department of Community Medicine
3800 Reservoir Road, NW
Kober Cogan 415
Washington, DC 20007

Michelle R. Schuder 650
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0365
schud001@gold.tc.umn.edu

Maureen E. Schuler 567
University of Maryland
Department of Pediatrics
700 West Lombard Street,
2nd Floor
Baltimore, MD 21201-1069
mschuler@umabnet.ab.umd.edu

Madelyn Schultz
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013-1182
mschultz@acf.dhhs.gov

Thomas W. Schultz
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Andrea F. Schuman
14 Charlemont Street
Newton, MA 02161
schuman@binah.cc.brandeis.edu

Ilene S. Schwartz 359
University of Washington
College of Education
Miller Hall
Seattle, WA 98195
ilene@u.washington.edu

Rita Schwarz
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Lawrence J. Schweinhart 106,
275, 278
High/Scope Educational
Research Foundation
600 North River Street
Ypsilanti, MI 48198-2898
hsresearch@aol.com

Richard K. Scotch
University of Texas at Dallas
School of Social Sciences
PO Box 830688
Richardson, TX 75083-0688

Carolyn Scott 640
Hartford Head Start
Community Renewal Team
55 Windsor Street
Hartford, CT 06120

Keith G. Scott 572
University of Miami
Department of Psychology, Annes
PO Box 249229
Coral Gables, FL 33124-0721
kscott@child.psy.miami.edu

Diane Scott-Jones 389
Temple University
Department of Psychology
1701 North 13th Street
Weiss Hall, Room 564
Philadelphia, PA 19122-6085

Judith Scully 562
Loyola University
Niehoff School of Nursing
6525 North Sheridan Road
Chicago, IL 60626

Mary Seaton 284, 285
Puget Sound ESD Head Start
400 SW 152nd Street
Burien, WA 98146-2209

Carol Seefeldt 626
University of Maryland
Institute for Child Study
College of Education
Department of Human Development
College Park, MD 20742-1131
cs14@umail.umd.edu

Victoria R. Seitz
Yale University
Department of Psychology
PO Box 208205
New Haven, CT 06520-8205

Ann Selmi 527
San Jose State University
Division of Special Education
One Washington Square
San Jose, CA 95192-0078

Sarah M. Semlak
12802 Via Nestore
Del Mar, CA 92014-3814

Arturo G. Sesma, Jr. 656
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0365
sesm0001@gold.tc.umn.edu

Margaret Garnett Sewell 525
University of Arizona
Division of Family Studies
PO Box 210033
Tucson, AZ 85721-0033
msewell@ccit.arizona.edu

Lois Sexton
Macon Program for Progress
Head Start
PO Box 700
Franklin, NC 28744
newhorizn2@aol.com

Cornelia Greaves Shafer 269,
273
Child Advocates of
Blair County, Inc.
Administration
319 Sycamore Street
Altoona, PA 16602-7004

Ariana Shahinfar 603
University of Maryland
Institute for Child Study
Department of Human Development
3304 Benjamin Building
College Park, MD 20742
ariana@umdd.umd.edu

Jacqueline D. Shannon
Little Sisters of the Assumption
Family Health Services, Inc.
426 East 119th Street
New York, NY 10035

Sharon Shapiro 214
MN Department of
Economic Security
Division of Head Start
Community Based Services
330 North Robert Street, Room 125
St Paul, MN 55101

Luminiza C. Shapp 630
Parents and Children Together
862 Main Street
Darby, PA 19023
shappiumi@aol.com

Phyllis Sharps 627
University of Maryland at Baltimore
School of Nursing
622 West Lombard Street
Baltimore, MD 21201
psharps@nurse-1.ab.umd.edu

Debra Shelapinsky 548
California University of Pennsylvania
Department of Nursing
333 Learning and Research Center
California, PA 15419

Terri L. Shelton
University of North Carolina at
Greensboro
Department of Psychology
285 Eberhart Building
Greensboro, NC 27412

Carey Wexler Sherman 519, 671
Wilder Research Center/Wilder
Foundation
1295 Bandana Boulevard North,
Suite 210
Saint Paul, MN 55108-5115

Lonnie R. Sherrod 43, 89, 453
William T. Grant Foundation
515 Madison Avenue, 8th Floor
New York, NY 10022-5403
lsherrod@sprynet.com

Mary M. Shiffer
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Stephanie Shine
3416 40th
Lubbock, TX 79413
xgshi@ttacs.ttu.edu

Virginia C. Shipman
4432 Glenwood Hills Drive, NE
Albuquerque, NM 87111-4261

Milton F. Shore
1370 Lambertson Drive
Silver Spring, MD 20902-3422

Rekhet Si-Asar 656
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345
fras004@maroon.tc.umn.edu

Mary Lou De Leon Siantz 127,
132, 148, 439
2525 Rock Creek Drive
Bloomington, IN 47401
msiantz@wpo.iupui.edu

Annette Sibley
Quality Assist, Inc.
368 Moreland Avenue, Suite 240
Atlanta, GA 30303

Gale Siegel
American Orthopsychiatric
Association
330 7th Avenue, 18th Floor
New York, NY 10001

Willa Choper Siegel
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013
wsiegel@acf.dhhs.gov

Sony Sierra 580
10 Yonge Street, #804
Toronto, Ontario, Canada M5E 1R4
sony.sierra@utoronto.ca

Suzanne Simon
Bussey Center for Early Childhood
Education
Southfield Public Schools
19080 West 12 Mile Road
Southfield, MI 48076
br10sfd@atlas.moa.net

Raghu N. Singh
East Texas State University
2900 Meadowview
Commerce, TX 75428

Sylvia W. Sirignano 251, 676
Wellesley College
Center for Research on Women
School Aged Child Care Project
Wellesley, MA 02181-8259

Larry Siroshon
Economic Opportunity Committee of
Clark County, Inc.
10621 NE Coday Drive, Suite 207
Vancouver, WA 98662-6122

Debra Skinner 609, 672
University of North Carolina-Chapel
Hill
Frank Porter Graham Child
Development Center
105 Smith Level Road, CB 8180
Chapel Hill, NC 27599-8180
skinner@email.unc.edu

Leona Skunk Cap
Blackfeet Teaching/Learning Center
PO Box 518
Browning, MT 59417

Evelyn Slaght 557
George Mason University
207 PE Building
Fairfax, VA 22030
eslaght@gmu.edu

Andrea B. Smith 632
Western Michigan University
Education and Professional
Development
Kalamazoo, MI 49008

Camille Smith 578
Centers for Disease Control
NCEH/BDDD
4770 Buford Highway, NE
Mailstop F-15
Atlanta, GA 30341
caso@cehbddd.em.cdc.gov

Evelyn Smith 465, 468
814 Arandell Street
Moorehead City, NC 28577

Judith Smith 575
Teachers College, Columbia
University
Center for Young Children and
Families
525 West 120th Street
Box 39
New York, NY 10027

Miriam W. Smith 127
Clark University
Education Department
950 Main Street
Worcester, MA 01610-1400
snowfdms@hugse1.harvard.edu

Ruth J. Smith
Title I
800 S. Belgrade Road
Silver Spring, MD 20902

Sheila A. Smith 306, 400
Foundation for Child Development
345 East 48th Street, Room 700
New York, NY 10017
hn5863@connect.inc.com

Wanda Smith 43, 89
Head Start of Greater Dallas, Inc.
1349 Empire Central, Suite 900
Dallas, TX 75247-4045

Ann Sneed
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Catherine E. Snow
Harvard Graduate School of
Education
Department of Education
14 Appian Way
313 Larsen Hall
Cambridge, MA 02138
snowcat@hugse1.harvard.edu

Charles W. Snow 647
East Carolina University
School of Human Environmental
Sciences
Department of Child Development
and Family Relations
Greenville, NC 27858-4353
hesnow@ecumv.cis.ecu.edu

Andrea Sobel
8328 The Midway
Annandale, VA 22003
asobel@gwis2.circ.gwu.edu

Jennifer Soderland 424
Northern Illinois University
Department of Educational
Psychology
Excellence in Education
Graham Hall
DeKalb, IL 60115

Karen Solomon 542
Chapel Hill Training and Outreach
800 Eastown Drive, Suite 105
Chapel Hill, NC 27514

Richard Solomon 485, 548
Allegheny General Hospital
Department of Pediatrics
Pittsburgh, PA 15212
solomon@asri.edu

Amy Sommer
20 Isabella Place
Glen Rock, NJ 07452

Fraya L. Sonenstein
The Urban Institute
Population Studies
2100 M Street, NW
Washington, DC 20037-1207

Susan Sonnenschein 269
University of Maryland
Baltimore County
Department of Psychology
5401 Wilkens Avenue
Baltimore, MD 21228-5398
sonnenschein@umbc2.umbc.edu

Ethel W. Spaight
4137 North Lake Drive
Shorewood, WI 53211

Adrienne B. Sparger
National Black Child Development
Institute
1023 15th Street, NW, Suite 600
Washington, DC 20005
asparger@aol.com

Marcia K. Spector 419, 420
Suffolk Network on Adolescent
Pregnancy
PO Box 5109
Bayshore, NY 11706-0082

Mark Spellmann 116
New York University School of
Social Work
Research Department
One Washington Square North
New York, NY 10003
spellmn@is2.nyu.edu

Margaret B. Spencer
University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19104-6216

Timothy Speth
Northwest Regional Educational
Laboratory
101 SW Main Street, Suite 500
Portland, OR 97204-3297
speth@nwrel.org

Susan Spieker
University of Washington
CHDD, South Building, Room 106
Box 357920
Seattle, WA 98195-7920
spieker@u.washington.edu

Donna K. Spiker 307
Stanford University
Department of Psychiatry
Mail Code 5540
Stanford, CA 94305

Iris E. Sroka
Research and Consulting
35-06 88th Street, Suite 6C
Jackson Heights, NY 11372

Jerry Sroufe
American Educational Research
Association
1230 17th Street, NW
Washington, DC 20036-3003
jsroufe@gmu.edu

Robert G. St. Pierre 175, 306, 308
Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138
bob_stpierre@abtlasoc.com

Ilene Staff 506
University of Connecticut Health
Center
Division of Child and Family Studies
309 Farmington Avenue
Farm Hollow, Suite A-200
Farmington, CT 06032
istaff@sun.uchc.edu

Vaughan Stagg 508
Theiss Center/WPIC
373 Burrows Street
Pittsburgh, PA 15204
stagg@andrew.cmu.edu

Martha D. Staker 402, 404
University of Kansas
Project Eagle, KUMC
Fourth and State Avenue
Gateway Tower II, Suite 1001
Kansas City, KS 66101

Prentice Starkey
University of California - Berkeley
School of Education and Institute of
Human Development
4511 Tolman Hall
Berkeley, CA 94720-0001
barbara1@violet.berkeley.edu

Sandra L. Starkey 642
College of Mount St. Joseph
5701 Delhi Road
Cincinnati, OH 45233-1670
sandra_starkey@mail.msje.edu

Mark A. Stein
University of Chicago
Department of Child and
Adolescent Psychiatry
5841 South Maryland Avenue
Chicago, IL 60637-1463

Suzanne Steinbach 326, 564
Boston City Hospital
818 Harrison Avenue
Maternity Building, 523
Boston, MA 02111
steinbch@acs.bu.edu

Anne F. A. Steiman 197
Aguirre International
411 Borel Avenue, Suite 402
San Mateo, CA 94402
asteiman@aism.attmail.com

Richard Sternowski
Administration on Children, Youth
and Families
Child Care Bureau
200 Independence Avenue, SW
Room 320 F
Washington, DC 20201
jsternowski@acf.dhhs.gov

Brenda A. Stevens 564
Miami University
Department of Educational
Psychology
201 McGuffey
Oxford, OH 45056
stevensb@muohio.edu

Harold W. Stevenson
University of Michigan
Center for Human Growth and
Development
300 North Ingalls Street
10th Floor
Ann Arbor, MI 48109-2007

Howard C. Stevenson 439
University of Pennsylvania
Graduate School of Education
Psychology in Education Division
3700 Walnut Street, Suite D-32
Philadelphia, PA 19104-6216
howards@nwfs.gse.upenn.edu

Anne Stewart
3224 Morrison Street, NW
Washington, DC 20015-1637

G. Keith Stewart
Consulting Psychology
800 Navarro, Suite 200
San Antonio, TX 78205

Paul Stewart 345
University of North Carolina
Biostatistics Department
McGavran Greenberg Hall
Chapel Hill, NC 27599

Karen Stiles
Camp Fire Boy and Girls
4601 Madison Avenue
Kansas City, MO 64112-1278

Dorothy M. Still Smoking
Montana State University
Blackfeet Tribe Head Start Program
PO Box 518
615 South Piegan
Browning, MT 59417

Deborah J. Stipek 374
University of California
Graduate School of Education
405 Hilgard Avenue
3302B Moore Hall
UES, Mailbox 951619
Los Angeles, CA 90095-1619
stipek@gse.ucla.edu

Jeffrey Stoddard 57
University of Wisconsin
Medical School
Meriter Hospital
202 South Park Street
6 Center
Madison, WI 53715
jstodda@facstaff.wisc.edu

Bertram Stoffelmayr 102, 103,
559
Michigan State University
Department of Psychiatry
Outcome Evaluation
B418A West Fee Hall
East Lansing, MI 48824
stoffel1@com.msu.edu

Zolinda Stoneman 132, 595
University of Georgia
College of Home Economics/UAP
Department
Dawson Hall, House D
Athens, GA 30602
zo@uga.cc.uga.edu

Kathlyn Chase Stovall 662
University of Delaware
Department of Psychology
Newark, DE 19716
kstovall@strauss.udel.edu

Joseph Stowitschek
University of Washington
C-Stars
4725 30th Avenue, NE
Seattle, WA 98105-4021
stowi@u.washington.edu

Joanne Straceski
7903 St. Martin's Lane
Philadelphia, PA 19118

Zvi Strassberg 421
SUNY at Stony Brook
Psychology Department
Stony Brook, NY 11794

Andrew J. Stremmel 102
Virginia Polytechnic Institute and
State University
Department of Family and Child
Development
Blacksburg, VA 24061-0416
stremmel@vtvm1.cc.vt.edu

Sebastian Striefel 556
Utah State University
Center for Persons with Disabilities
Community-Family Partnership
Logan, UT 84322-6825

Michele A. Strobridge 569
Washington County Head Start
Special Education Department
18 River Street
Hudson Falls, NY 12839-1308

Michelle E. Strollo 502
George Mason University
Psychology Department
Mailstop 3F5
Fairfax, VA 22030-4444
mstrollo@aol.com

Allen R. Sullivan
Head Start Transition - Dallas
Student Support Services
3700 Ross Avenue, Box 39
Dallas, TX 75204-5474

Elizabeth C. Sullivan 599
Pacific Lutheran University
Marriage and Family Therapy
Program
East Campus
Tacoma, WA 98447

Maureen A. Sullivan 497
East Carolina University
Department of Child Development
and Family Relations
Greenville, NC 27858
hesulliv@eluvn.cis.ecu.edu

Jean Ann Summers 402, 403
University of Kansas
Juniper Gardens Children Project
1614 Washington Boulevard
Kansas City, KS 66102

Amy R. Susman-Stillman 652
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345
sussm0001@gold.tc.umn.edu

Beverly Swanson
Aspen Systems Inc.
1600 Research Boulevard
MS #5F
Rockville, MD 20850-3172
bwsanson@aspensys.com

Mark Swanson
University of Arkansas for Medical
Science
1120 Marshall, Suite 306
Little Rock, AR 72202
eswanson@go.ach.uams.edu

E. Brigitte Syfrett 579
Toledo Hospital
Reuben Center for Women and
Children
2142 North Cove Boulevard
Toledo, OH 43606

Maurice Sykes
Center for Systemic Educational
Change
District of Columbia Public Schools
415 12th Street, NW
Suite 805
Washington, DC 20004-1905

Lori Connors Tadros
8401 Joseph Sharp, NE
Albuquerque, NM 87122-2810

Ronda C. Talley
American Psychological Association
425 8th Street, NW, #538
Washington, DC 20004
ret.apa@email.apa.org

Shannon Tanaka 186, 253
MMAC Project Head Start
800 Los Vallecitos Boulevard
San Marcos, CA 92069

Howard L. Taras 516
University of California at San Diego
Community Pediatrics
Department 0927
9500 Gilman Drive
La Jolla, CA 92093-0927
htaras@ucsd.edu

Nancy Tarsi 639
University of Tennessee at Knoxville
Psychoeducational Studies Unit
Knoxville, TN 37996-3400

Louisa B. Tarullo 175, 186
Administration on Children, Youth
and Families
330 C Street, SW
Switzer Building Room 2411
Washington, DC 20201
lbtarullo@acf.dhhs.gov

Marc J. Tasse 610
Universite du Quebec a Montreal
PO Box 8888
Station Center-Ville
Montreal, Quebec,
Canada H3C 1P8
tasse.marc_j@uqam.ca

Angela R. Taylor 525, 585
University of Arizona
Division of Family Studies
School of Family and Consumer
Resources
210 FCR Building
Tucson, AZ 85721
artaylor@ccit.arizona.edu

Heleen H. Taylor
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013

Karen Taylor 501, 542
Chapel Hill Training and Outreach
800 Eastown Drive, Suite 105
Chapel Hill, NC 27514
taylor@fpg.mhs.unc.edu

Mary Ann Taylor
Community Services for
Children, Inc.
431 East Locust Street
Bethlehem, PA 18018
pwlevin@aol.com

Matthew Taylor 127, 128
Early Intervention Research Institute
Center for Persons with Disabilities
Utah State University
UMC 6580
Logan, UT 84322-6580
mtaylor@cpd2.usu.edu

Nancy E. Taylor
Catholic University
226 O'Boyle Hall
Washington, DC 20064
taylor@cua.edu

Susan Taylor-Brown
Syracuse University
School of Social Work
313 Sims Hall
Syracuse, NY 13224

Jackqueline Teague
Research Triangle Institute
PO Box 12194
Research Triangle Park, NC 27709

Jane King Teleki 647
East Carolina University
School of Human Environmental
Sciences
Department of Child Development
and Family Relations
Greenville, NC 27858-4353
heteleki@ecuvm.cis.ecu.edu

Sharon L. Telleen
University of Illinois at Chicago
School of Public Health
912 Greenleaf Avenue
Wilmette, IL 60091-2705
telleen@uic.edu

Richard E. Temblay 636
Universite de Montreal
Ecole de Psycho-Education
750 Gouin Boulevard East
Montreal, Quebec,
Canada H2C 1A6

Judy Temple
Northern Illinois University
Department of Economics
DeKalb, IL 60115-6712
ta0jat1@mvs.cso.nui.edu

Mary Temple 653
Rochester Preschool-Parent
Program in the
Rochester City School District
198 Bronson Avenue, Room 27
Rochester, NY 14611

Oneta Templeton-McMan 403
Children's Mercy Hospital
2401 Gillham Road
Kansas City, MO 64108-4619

Betsy T. Thigpen 106, 647
Wayne Action Group for Economic
Solvency, Inc.
Child and Family Development
Program
601 East Royall Avenue
Goldsboro, NC 27534-2570

Cynthia Thomas
CEDA Head Start
224 North Des Plaines
c/o Sandra Van
Chicago, IL 60661

David Thomas
Caliber Associates
10530 Rosehaven Street, Suite 400
Fairfax, VA 22030
thomasd@calib.com

Jim Thomas
San Antonio Metro Health District
203 West Commerce
San Antonio, TX 78203
jthoma@ci.sat.us

Marilyn E. Thomas 275
Miami Valley Child Development
Center, Inc.
215 Horace Street
Dayton, OH 45407

Susan Thomas 359
Prince George's County Public
Schools
8801 Richie Road
Capital Heights, MD 20743

Yonette F. Thomas 175
8111 Felbrigg Hall Road
Glenn Dale, MD 20769
yonette.thomas@pressroom.com

Judith Thomas-Blake
CSR, Inc.
1400 Eye Street, Suite 200
Washington, DC 20005

Ray H. Thompson 674
University of South Dakota
School of Education
414 East Clark Street
Vermillion, SD 57069-2307
rthomps@charlie.usd.edu

Ruby J. Thompson
OK Association of Community
Action
State Head Start Office
2915 Classen Boulevard, Suite 215
Oklahoma City, OK 73106

Kathy Thornburg
University of Missouri at Columbia
Department of Human Development
and Family Services
32 Stanley Hall
Columbia, MO 65211
cdfkathy@mizzou1.missouri.edu

Judy Thorne
Research Triangle Institute
PO Box 12194
Research Triangle Park, NC 27709

Nancy G. Torp 654
Department of Agriculture
Cornell Cooperative Extension -
Allegheny County
RD 1, Box 226
County Road 48
Belmont, NY 14813
ntorp@cce.cornell.edu

Tom R. Torres
Development Associates, Inc.
Head Start Resource Center
1475 North Broadway, Suite 200
Walnut Creek, CA 94596-4643

Yolanda L. Torres
Pacific Oaks Children's School
714 West California Boulevard
Pasadena, CA 91105

Carol C. Torrey 634
Southeastern Louisiana University
Department of Special Education
SLU 879
Hammond, LA 70402
ctorrey@selu.edu

Kathryn Tout 620
University of Minnesota
Institute of Child Development
51 East River Road
Minneapolis, MN 55455-0345
toutk001@maroon.tzumn.edu

Lisa Towne
Caliber Associates
10530 Rosehaven Street, Suite 400
Fairfax, VA 22030
townel@calib.com

Elizabeth M. Tracy 532, 554
Mandel School of Applied Social
Sciences
11235 Bellflower Road
Cleveland, OH 44106-7164
ext@pop.cwru.edu

Darren C. Treasure 565
Southern Illinois University at
Edwardsville
Department of Health, Recreation
and Physical Education
Edwardsville, IL 62026-1126
dtreasu@eniac.siu.edu

Dominique Treboux 419, 421
SUNY at Stony Brook
Psychology Department
Stony Brook, NY 11794-2500
dtreboux@psych1.psych.sunysb.edu

Penelope K. Trickett 216
University of Southern California
Departments of Psychology and
Gerontology
Seeley G. Mudd Building
Los Angeles, CA 90089-1061
pennyt@rcf.usc.edu

Barbara Tripp 560
Wayne State University
Center for Urban Studies/Urban
Families Program
656 West Kirby
Room 3261, Faculty Administration
Building
Detroit, MI 48202
btripp@cms.cc.wayne.edu

Edward Z. Tronick 581
Children's Hospital
Child Development Unit
1295 Boylston Street, Suite 320
Boston, MA 02215
tronick@al.tch.harvard.edu

Pat Truhn 556
Utah State University
Center for Persons with Disabilities
Community-Family Partnership
Logan, UT 84322-6825

Jeanne M. Tschann 348, 349
University of California
CSBS, PO Box 0844
San Francisco, CA 94143-0844

Harla Tumbleson
City of Seattle
618 2nd Avenue, 6th Floor
Seattle, WA 98104
harla.tumbleson@cit.seatl.wa.us

Rosanne Turner
Rural Alaska Community Action
Program, Inc.
PO Box 200908
Anchorage, AK 99520-0908

Ann Turrell 539
University of Rochester
Warner Graduate School of
Education and Human Development
Rochester, NY 14627

Rachelle Tyler
University of California -
Los Angeles
Department of Pediatrics
Developmental Studies Program
300 UCLA Medical Plaza,
Suite 3300
Box 957033
Los Angeles, CA 90095-7033

Christine Tyrrell 604
University of Delaware
Department of Psychology
Newark, DE 19716-2577
ctyrrell@strauss.udel.edu

Donald G. Unger 635
University of Delaware
Department of Individual and Family
Studies
111 Alison Hall West
Newark, DE 19716-3301
donald.unger@mvs.udel.edu

Felicia M. Valdez 508
Children's Hospital
Department of Hearing and Speech
111 Michigan Avenue, NW
Washington, DC 20010

Laura Vandewiele
Quality Assist, Inc.
368 Moreland Avenue, Suite 240
Atlanta, GA 30307
LVandew@aol.com

Maribel Vargas
Fordham University
Department of Psychology-
Dealy Hall
Bronx, NY 10458

Anita Varne
Iowa Department of Education
Head Start Collaboration Project
Grimes State Office Building
Des Moines, IA 50319-0146

Rebecca Vasquez 654
University of California-Riverside
Department of Psychology-075
Riverside, CA 92521

Brian E. Vaughn 613
Auburn University
Department of Family and Child
Development
203 Spidle Hall
Auburn, AL 36849-5604
bvaughn@humsci.auburn.edu

Trudi L. Venters Horton 509
University of Alabama at
Birmingham
Civitan International Research
Center
SC 313, Department of Psychology
c/o Shirley L. Robinson
Birmingham, AL 35294-0017

Marce A. Verzarro-O'Brien 427
640 99th Street Ocean
Marathon, FL 33050-3380

Pedro A. Vieira 563
Rutgers University
Cook College/Nutritional Sciences
26 Nichol Avenue
Davison Hall
New Brunswick, NJ 08903-0270
pvieira@eden.rutgers.edu

Lawrence A. Vitulano
163 Carroll Road
Fairfield, CT 06430

Joan I. Vondra 485, 548
University of Pittsburgh
Department of Psychology in
Education
5C01 Forbes Quad
Pittsburgh, PA 15260

Mary M. Wagner
SRI, International
Education and Human Services
Research
333 Ravenswood Avenue
Menlo Park, CA 94025-3453

Ruth A. Waibel 345
22700 South Route 50 East
Coolville, OH 45723

Lisa R. Wakeem-Caya 648
University of Texas
Department of Human Ecology
Austin, TX 78712

Pamela L. Walker
Montgomery County Public Schools
4910 Macon Road
Rockville, MD 20852

Todd B. Walker 400
AVANCE, Inc.
301 South Frio Street, Suite 310
San Antonio, TX 78207-4425

Shavaun Wall
Catholic University of America
620 Michigan Avenue, NE
Washington, DC 20064
wallis@cua.edu

Ina F. Wallace
Research Triangle Institute
PO Box 12194
Research Triangle Park, NC 27709

Julia W. Wallace 651
177 North Liberty
New Concord, OH 43762
wiwallace@muskingum.edu

Charlotte Wang 421
SUNY at Stony Brook
Psychology Department
Stony Brook, NY 11794

Margaret C. Wang
Temple University Center
Research in Human Development
and Education
933 Ritter Hall Annex
13th Street and Cecil B. Moore
Avenue
Philadelphia, PA 19122

Barbara Wash 103, 551
Detroit Health Department
Detroit-Skillman Parenting Program
1151 Taylor, Building 4, Room 110
Detroit, MI 48202

Valora Washington
W.K. Kellogg Foundation
1 Michigan Avenue East
Battle Creek, MI 49017-4005

Wanda Newell Washington 613
PO Box 71081
Tuscaloosa, AL 35407-1081

Nancy M. Watt 666, 667
3616 Jennifer Street
Chevy Chase, MD 20015

Norman F. Watt 633
University of Denver
Department of Psychology
2155 South Race Street
Frontier Hall
Denver, CO 80208
nwatt@pstar.pay.du.edu

Trellis L. Waxler
Administration on Children, Youth
and Families
Head Start Bureau
PO Box 1182
Washington, DC 20013-1182

Mary B. Webb 163
Administration on Children, Youth
and Families
330 C Street, SW
Switzer Building, Room 2411
Washington, DC 20201
mbwebb@acf.dhhs.gov

Carolyn Webster-Stratton 146
University of Washington
School of Nursing, SC-74
1107 NE 45th Street, Suite 305
Seattle, WA 98105

Rebecca Weerts
Kankakee County Head Start
710 North Chicago Avenue
Kankakee, IL 60901

David P. Weikart 278
HighScope Education Research
Foundation
600 North River Street
Ypsilanti, MI 48198-2821

Heather B. Weiss 149, 611
Harvard Family Research Project
Harvard Graduate School of
Education
38 Concord Avenue
Longfellow Hall, Appian Way
Cambridge, MA 02138-2357

Patricia Weissman 530
Wayne State University
Merrill-Palmer Institute
5959 Woodward
Detroit, MI 48202
pwissm@aol.com

Chiquitia Welch
Center for Families and Children
11317 Proctor Court
Cleveland, OH 44105

Mara Welsh 615, 654
University of California-Riverside
Department of Psychology-075
Riverside, CA 92521
star@citrus.ucr.edu

Emmy E. Werner 27, 360
University of California Davis
Department of Applied Behavioral
Sciences
2321 Hart Hall
Davis, CA 95616

Melissa Werner
University of Alabama at
Birmingham
1804 Old Creek Trail
Birmingham, AL 35216

Donald Wertlieb
62 Lenox Street
West Newton, MA 02165

Jerry West 133
National Center for Education
Statistics
Early Childhood Longitudinal Study
555 New Jersey Avenue, NW
Room 417B
Washington, DC 20208-0001
Jerry_West@ed.gov

Miriam Westheimer 308
Teachers College, Columbia
University
Hippy USA
Box 113
525 West 120th Street
New York, NY 10027

C. Stephen White 679
George Mason University
Graduate School of Education
MSN 483
Fairfax, VA 22030
cwhite1@osp1.gmu.edu

Davene White 640
Howard University Hospital
Pediatrics
2041 Georgia Avenue, NW
Washington, DC 20060

Donna R. White 491
Concordia University
Center for Research in Human
Development
Department of Psychology
7141 Sherbrooke Street West
Montreal, Quebec,
Canada H4B 1R6
dwhite@vax2.concordia.ca

Lucie E. White
Harvard Law School
1525 Massachusetts Avenue
Griswold 304
Cambridge, MA 02138
lwhite@law.harvard.edu

Sheldon H. White 75, 149, 275
Harvard University
Department of Psychology
33 Kirkland Street
William James Hall
Cambridge, MA 02138-2044
shw@isr.harvard.edu

Grover J. Whitehurst 144, 145
State University of New York - Stony
Brook
Psychology Department
Stony Brook, NY 11794-2500
gwhitehurst@ccmail.sunysb.edu

Karen A. Whiten
U.S. General Accounting Office
GAO/HEHS
441 G Street, NW
NGB, Suite 650
Washington, DC 20548
whitenk.hehs@gao.gov

Mark F. Whitney 582
Syracuse University
Department of Child and Family
Studies
201A Slocum Hall
Syracuse, NY 13244
mfwhitne@mailbox.syr.edu

Louise W. Wiener
Museum as a Resource
PO Box 6286
Washington, DC 20015
museumreso@aol.com

Carolyn Wiggins
Ft. George Community Enrichment
Center
1525 St. Nicholas Avenue
New York, NY 10033

Edith L. Williams 631
Chicago Read Mental Health Center
4200 North Oak Park Avenue
Chicago, IL 60634-1471
ediewms@aol.com

H. Stephen Williams 43, 89
Mott Children's Health Center
806 Tuuri Place
Flint, MI 48503
hwilliams@msms.org

Irene Williams
Columbia University
Teachers College
49 East 96th Street, #14
New York, NY 10128

Joann Williams
Child Development, Inc.
Arkansas Head Start Association
PO Box 2110
Russellville, AR 72811
arhyne@cswnet.com

Kimberly P. Williams 439
Erikson Institute for the Advanced
Study of Child Development
420 North Wabash Avenue
Chicago, IL 60611-2254
uckim@aol.com

Marsha E. Williams 566
Children's Television Workshop
1 Lincoln Plaza
New York, NY 10023
marshwms@aol.com

Myrna B Williams
2004 Claxton Drive
Winston-Salem, NC 27127

Rosanne Williams 311, 493
University of South Dakota
414 East Clark
Vermillion, SD 57069
rwilliam@charlie.usd.edu

David L. Williams, Jr.
SW Educational Development Lab
211 East 7th Street
Austin, TX 78701
dwilliam@sedi.org

Angela Willson-Quayle
2700 Pleasantdale Road,
Apartment 101
Vienna, VA 22180

Grace Wilson 271, 273
Patchogue Head Start
98 Austin Street
Patchogue, NY 11772

Harry I Wilson
511 Albion Road
Albion, MI 49224

Modena Wilson
Johns Hopkins Hospital
General Pediatrics
600 North Wolfe Street
Building CMSC 144
Baltimore, MD 21287

Sallie L. Wilson 596
California Department of Education
Elementary Teaching and Learning
Division
721 Capitol Mall, 3rd Floor
PO Box 944272
Sacramento, CA 95814
swilson@cde.ca.gov

Nancy W. Wiltz 614
University of Maryland
Curriculum and Instruction
2311A Benjamin Building
College Park, MD 20742
nw17@uemail.umd.edu

John B. Wingate 419
Suffolk County Department of Social
Services
PO Box 2000
Hauppauge, NY 11788

Janet M. Wise
City of Phoenix Head Start
200 West Washington, 19th Floor
Phoenix, AZ 85003

Debbie Wolcott
National Clearinghouse on Child
Abuse and Neglect
10530 Rosenhaven Street,
Suite 400
Fairfax, VA 22030
wolcott@calib.com

Pamela J. Wolfberg 359
San Francisco State University
Department of Special Education
4 Tapia Drive
San Francisco, CA 94132
wolfberg@sfsu.edu

Clara Wolman 513
Barry University
11300 2nd Avenue, NE
Miami Shores, FL 33161

Karren Wood
2234 North Madison Street
Arlington, VA 22205
kwood@gws2.circ.gwu.edu

Marianne Woodside 639
University of Tennessee at Knoxville
Office of Chancellor
Knoxville, TN 37996

Susan Workman
San Juan College
109 East 30th Street
Farmington, NM 87401

Harriet S. Worobey 563
Rutgers University
Cook College/Nutritional Sciences
26 Nichol Avenue, Davison Hall
New Brunswick, NJ 08903-0270

John Worobey 563
Rutgers University
Cook College/Nutritional Sciences
26 Nichol Avenue
Davison Hall, 211
New Brunswick, NJ 08903-0270
worobey@gandalf.rutgers.edu

Sheli Wortis 541
Early Childhood Connections
Cambridge School Department
159 Thorndike Street
Cambridge, MA 02141

DeeAnn Wright 133
National Center for Education
Statistics
Early Childhood Longitudinal Study
555 New Jersey Avenue, NW,
Room 417B
Washington, DC 20208-0001
DeeAnn_Wright@ed.gov

Juliet Wright
DCPS-Head Start Program
12th and Jasper Road, SE
Washington, DC 20032

Jannette Wundrow 359
Prince George County Maryland
Head Start
1007 Packton Lane
Bowie, MD 20716

Barbara Wyer
1401 Blair Mill Road
Silver Spring, MD 20910

Yu Xie 278
University of Michigan
Population Studies Center
1225 South University Avenue
Ann Arbor, MI 48104-2590

Fred Yohey
General Accounting Office
441 G Street, NW
Washington, DC 20548

H. Lorrie Yoos 570
University of Rochester
School of Nursing
601 Elmwood Avenue, Box SON
Rochester, NY 14642
yoos@son.rochester.edu

Hiro Yoshikawa 604
New York University
Department of Psychology
Head Start/Mental Health Task
Force
6 Washington Place, 4th Floor
New York, NY 10003
hiro@xp.psych.nyu.edu

Michal Young 568
DC General Hospital
1900 Massachusetts Avenue, SE
Washington, DC 20003

Sarah Younglove
Administration on Children, Youth
and Families
Head Start Bureau
330 C Street, SW
Switzer Building
Washington, DC 20032

Anita Yusem
United Cerebral Palsy Association
Box 332
Gwynedd Valley, PA 19437

Carolyn Zahn-Waxler
National Institute of Mental Health
Developmental Psychology Lab
9000 Rockville Pike, Building 15K
Bethesda, MD 20892
eic@nihcu.gov

Ruth Zambrana 557
George Mason University
Center for Child Welfare
305 Carroll Hall
Fairfax, VA 22030
rzambran@gmu.edu

Nellie Zambrana-Ortiz 612
676 Violeta Round Hill
Trujillo Alto, Puerto Rico 00976
n_zambrana@upr1.upr.cu.edu

Jennifer Zanger 423
Center for Family Life in
Sunset Park
345 43rd Street
Brooklyn, NY 11220

Martha J. Zaslow 308
Child Trends, Inc.
4301 Connecticut Avenue, NW
Suite 100
Washington, DC 20008-2304

Shepherd Zeldin 370
Fund for Communities' Future
1135 15th Street, Suite 605
Washington, DC 20005

Mariene Zepeda 576
Cal-State University Los Angeles
Department of Child and Family
Studies
5151 State University Drive
Los Angeles, CA 90032
mzepeda@calstatela.edu

Andrea A. Zevenbergen 145,
269, 271, 273, 638
21W580 Lynn Road, Apartment 23
Lombard, IL 60148

Edward F. Zigler 1, 75
Yale University
Department of Psychology
PO Box 208205
New Haven, CT 06520-8205

Caroline Zinsser
Rockefeller Brothers Fund
1290 Avenue of the Americas,
Suite 3450
New York, NY 10104

Robert A. Zucker 503
University of Michigan
Department of Psychiatry-UMARC
400 East Eisenhower Parkway,
Suite 2A
Ann Arbor, MI 48106-3318
zuckerra@umich.edu